

## Inquiry into protected disclosures SU1

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## **Final Report**

# **Inquiry into Protected Disclosures, SU1**

**March 2012**

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# 1. Terms of Reference

## 1.1. *Introduction*

- 1.1.1. These are the terms of reference for an inquiry into issues raised and related matters in the protected disclosures made by two employees of ID1 and which was commissioned by (named [REDACTED] HSE).

Details of the disclosure are outlined in the following which are attached:

- E-mail dated 20<sup>th</sup> of November 2009;
- Letter dated 26<sup>th</sup> of November 2009, and supported by documents (Reference 1 – 29);
- E-mail dated 17<sup>th</sup> of January;
- Additional Information has been supplied to the Authorised Person by a HSE employee on 1<sup>st</sup> March 2010.

The purpose of this inquiry is to:

- Establish the chronology of events leading up to the issues disclosed
- Identify any care/service delivery problems\* that may have occurred
- Identify the causes of the care/service delivery problems
- Recommend actions that will address the causes of the care/service delivery problems so that the likelihood of future harm arising from these causes is reduced as far as is reasonably practicable.

Membership of the inquiry team is:

- Mr. Conal Devine, Chairperson
- Ms. Breda Mulvihill,
- Ms. Anne Wall

The Chair, with the approval of the Commissioner, may source appropriate expertise as required from relevant areas.

Through the Chairperson, the inquiry team will:

- Be afforded the assistance of all relevant staff (including former staff) and other relevant personnel.
- Have access to all relevant files and records.

The inquiry will have regard to the systems analysis method of inquiry outlined in the HSE Incident Management Tool-kit. It will be conducted in a manner that is impartial and effective at achieving its purpose and is cognisant of the rights of all involved to privacy and

confidentiality; dignity and respect; due process; and natural and constitutional justice.

The inquiry will commence on the first of March 2010 and will be expected to last for a period of approximately 9 weeks, provided some unforeseen circumstance does not arise.

Following completion of the investigation, an anonymised draft report will be prepared by the inquiry team outlining the chronology, findings and recommendations. All who participated in the inquiry will have an opportunity to give input into the extracts from the report relevant to them for factual accuracy and to respond to any matters that may be considered adverse to them. The final anonymised report will be submitted to the commissioner for appropriate circulation.

The outcome of the report, as far as possible and subject to any legal constraint, will be communicated to the two employees of [REDACTED] who made the disclosures.

**Reference:**

HSE 2009, *"Toolkit of Documentation to Support Health Service Executive Incident Management"*.

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\* **Care delivery problems (CDP's)** are defined as problems that arise in the process of care, usually actions or omissions by members of staff. They have two essential features:

- Care deviated beyond safe limits of practice
- The deviation had at least a potential direct or indirect effect on the eventual adverse outcome for the service user, member of staff or the general public.

Examples of CDP's are:

- Failure to monitor
- Incorrect (with hindsight) decision
- Not seeking help when necessary

\* **Service delivery problems (SDP's)** are defined as failures identified during the analysis of the incident which are associated with the way a service is delivered and the decisions, procedures and systems that are part of the whole process of service delivery.

## 2. Methodology/ Inquiry Process

### 2.1. *The following methodology was adopted by the Inquiry Team*

- (i) *The Inquiry will be chaired by Mr. Conal Devine and will have regard to relevant HSE policies and Statutory and non statutory guidelines relating to the care and protection of children and vulnerable adults. Where any potential breaches of such policies or guidelines by current or serving HSE staff are identified, these will be documented by the Inquiry Team and referred to the HSE as Decision Maker on the appropriate action, if any, to be taken. The Membership of the Inquiry Team is as follows –*  
*Mr. Conal Devine, Chair*  
*Ms. Breda Mulvihill, National Disabilities Office, HSE*  
*Ms. Anne M. Wall, Principal Social Worker HSE (Principal Social Worker, Cregg House Sligo from September 2010)*
- (ii) *The Inquiry will be conducted in accordance with principles of natural justice and will have full regard to the Protected Disclosure Provisions of Part 14 of the Health Act 2007 and Part 9A of the Health Act 2004.*
- (iii) *The standard and burden of proof in examining the allegations/complaints made will be the civil standard.*
- (iv) *The [REDACTED] and [REDACTED] making the Protected Disclosure will be interviewed in respect of the written documentation furnished by them in (correspondence with attachments) dated 20 and 26 November 2009. This interview may take place in the presence of a Trade Union, or professional body or a colleague who is otherwise uninvolved in the matters under Investigation.*
- (v) *The individual [REDACTED] staff member who furnished file reports and documentation under Section 103 of the Health Act*

- 2007 relating to the Protected Disclosure made by the persons indicated in clause iv above will be interviewed*
- (vi) The Inquiry Team will also interview other persons who are named as individuals or representatives of Organisations referred to in the Protected Disclosure Documentation and any other party, who, in the opinion of the Inquiry Team, can assist in establishing the facts*
  - (vii) Parties who may be potentially adversely affected by the Protected Disclosures will be provided with documentation contained in the Protected Disclosures as it relates to them. Such parties will also be given the opportunity to indicate other individuals to be interviewed who may be in a position to assist in establishing relevant facts*
  - (viii) Draft summaries of interviews will be provided to interviewees to check on factual accuracy and to any parties within the HSE or Nominated Health Agency, or other parties who may be adversely affected by any such statements, prior to summaries of such interviews being placed on the record.*
  - (ix) Following completion of the first series of interviews, the Inquiry Team will distribute draft preliminary findings of fact emerging from the Inquiry to the parties and to the Commissioning Body for comment/confirmation. Where any such preliminary findings of fact may be adverse to any party, such parties will be invited to comment or to meet with the Inquiry Team for a final meeting.*
  - (x) Final interviews with the relevant parties will be conducted at the earliest date following issuing of the draft preliminary findings of fact. The final interviews will give an opportunity to parties, particularly those who may be potentially adversely affected by such draft findings, to address issues*

*arising from the first set of interviews and to make concluding statements.*

- (xi) *A final report will issue to ( [REDACTED] HSE) within a period of 4 weeks from the date of receipt of comments from the parties arising from the draft findings. Any separate matters of concern which emerge in the course of the Inquiry but which fall outside of the terms of reference, will be separately documented and furnished to the [REDACTED] Health Service Executive.*
- (xii) *Confidentiality will be maintained as far as practicable. The parties and those accompanying them at interview, will be expected to give an undertaking to respect the privacy of those involved, or named in the disclosures, by refraining from discussing the allegations with other work colleagues or any other person.*

## **2.2. Inquiry Process**

2.2.1. The Inquiry Team examined the disclosures made through:

- An examination of all available files relating to the care and management of Service User SU1
- Conducting initial interviews with the Disclosers and all identifiable staff and former staff who had an involvement in the care and management of SU1 from the initial decision to place SU1 with the [REDACTED] in 1989 until the admission of SU1 as a Ward of Court in March 2010
- Conducting follow up interviews with the Disclosers and relevant staff and former staff.

2.2.2. Following approximately 21 meetings of the Inquiry Team, including approximately 33 interviews with staff and former staff, the Inquiry Team produced a draft chronology of significant events relating to the care and management of SU1. 27 redacted versions of that draft chronology were produced and issued to individuals interviewed and other relevant individuals who did not present for interview. This documentation was issued on 24<sup>th</sup> November 2010 and

recipients were invited to respond to the draft chronology. 15 responses to the draft chronology were received.

- 2.2.3. One recipient of the draft chronology issued a substantive response via a solicitor. As this response included indications that this party would initiate a Judicial Review Application to the High Court unless the Inquiry Team gave certain assurances, the Inquiry Team was compelled to obtain detailed legal advice. Acting on that advice the Inquiry Team provided a substantive response to that party's solicitors on 31 January 2011.
- 2.2.4. Substantive correspondence was also exchanged with one of the disclosers, PD3, who raised concerns around the documentation of that party's interventions in respect of the care and management of SU1. A number of invitations were extended to that individual to provide a detailed written account of those concerns so that it could be reflected in the chronology of key events. The Inquiry Team met with PD3 on 11<sup>th</sup> February 2011 in an effort to progress this issue but there was no further response from PD3 with the result that the Inquiry Team is not in a position to include draft summaries of its interaction with PD3 in this Final Report.
- 2.2.5. Having regard to the responses to the draft chronology and the exchanges with PD3 in particular, the Inquiry Team made revisions to the chronology and proceeded to prepare draft findings on the basis of the key events as established.
- 2.2.6. On 28 February 2011 the Chair of the Inquiry Team received a telephone call from the Commissioner of the Inquiry indicating that [REDACTED] had been advised that due to a formal complaint being made to the Gardai in respect of aspects of the care of SU1 and other service users who had attended the former foster placement, that all investigations including the work of the Inquiry Team was to cease immediately. On 7<sup>th</sup> March the Chair of the Inquiry Team formally corresponded with the HSE seeking additional detail in respect of the Garda involvement. The investigating Gardai were identified to the Inquiry Team and contact was made with those Gardai and arrangements made to meet on 18 March 2011.
- 2.2.7. The Inquiry Team met with investigating Gardai and senior Gardai on 18<sup>th</sup> March 2011 and on being advised of the nature of the Protected Disclosure Inquiry, the Gardai stated that they had no objection to the Inquiry proceeding. The Gardai further advised that they would be meeting with the HSE and would be confirming this directly to the HSE. Formal confirmation was issued to the HSE by An Garda Síochána on 11 May 2011 confirming that there was no Garda objection to

the Independent Inquiry completing its task parallel with the Garda investigation.

2.2.8. The Inquiry Team recommenced its work on 19<sup>th</sup> May following the ten week period from when it was requested to cease its work. The Inquiry Team had advised the HSE in December 2010 that, following legal advice, it was obliged to communicate with the former foster mother of the service user who was the subject of the Inquiry. Acting on that advice, the Inquiry Team advised the HSE that it could not proceed to engage with the former foster mother until such time as clarification had been obtained from the HSE at [REDACTED] level on steps taken, or to be taken, to engage with the former foster mother on notifying her of historic allegations relating to the placement. The HSE met with the former foster mother on 17<sup>th</sup> June 2011 and also received advice on that date from An Garda Síochána that the former foster mother should not be interviewed as part of an internal HSE investigation until the Gardai had formally interviewed her.

2.2.9. The Inquiry Team wrote to An Garda Síochána on 22 June 2011 confirming a telephone conversation of the previous day relating to the Inquiry Team proceeding to make contact with the former foster mother and whether An Garda Síochána had any objections to the Inquiry Team making such direct contact. An Garda Síochána formally wrote to the Inquiry Team on 4<sup>th</sup> August 2011 confirming that there was no objection to the Inquiry Team interviewing the former foster mother and no objection *"to you completing and publishing your report into the case"*. On receipt of that correspondence the Inquiry Team proceeded to write to the former foster mother indicating a series of topics that it wished to discuss with the former foster mother and made arrangements to meet with the former foster mother on 17<sup>th</sup> August 2011. The interview took place on that date and the former foster mother signed and returned the minutes of that meeting on 2<sup>nd</sup> September 2011.

2.2.10. On 28<sup>th</sup> September the Inquiry Team wrote to the HSE stating that it had received legal advice on the completion and distribution of draft findings. That advice included a recommendation that specific detail in respect of allegations relating to other service users who attended the former foster placement should not be included in the report as such inclusion may be outside of the terms of reference of the Inquiry. Accordingly the Inquiry Team recommended that the HSE would satisfy itself that those historic cases had been, or would be, comprehensively reviewed outside of this Inquiry process. In order to assist in that review, a summary of the

information relating to those historic issues which came to the attention of the Inquiry Team in the course of its work was furnished to the HSE. The HSE was also advised that the former foster mother had indicated that she had no knowledge of the detail of any historic allegations relating to service users attending the placement and there was no record on file of the detail of any such allegations being provided to her. The Inquiry Team was advised by the HSE on 19<sup>th</sup> December 2011 that it had written to the former foster mother and had made arrangements to meet with her to provide her with further detail around historic issues in relation to other service users. Following receipt of that confirmation, the Inquiry Team wrote to the former foster parent with an extract from the draft findings directly relating to interactions between her, her late husband, and the Health Services. The former foster mother was provided with an opportunity to comment on the accuracy of how those interactions were reflected in the report and to provide a response by 10 January 2012. No further response was received by the Inquiry Team from the former foster mother (■■■■■)

2.2.11. The Inquiry Team concluded draft findings in September 2011 and provided a number of parties with additional information from 1996, 2001, and 2009 for comments to that additional information which had not been included in the chronology of key events previously circulated to the parties. Thirty redacted versions of draft findings were issued to the various parties and they were invited to comment on those draft findings prior to finalisation. Substantive correspondence was issued by the party who had previously corresponded through their solicitor in December 2010. Arising from that correspondence additional enquiries were made by the Inquiry Team and an additional meeting was held with that party at the end of November 2011 and copies of all documentation including minutes of interviews which referred to that individual, were furnished. Arising from those submissions and the additional enquiries made by the Inquiry Team, the draft findings were adjusted to take account of those submissions/additional information.

2.2.12. A separate party sought additional time to provide a response to the draft findings as they related to that party. This was facilitated by the Inquiry Team and there followed substantive correspondence between the Inquiry Team and solicitors representing that individual. A substantive response was provided to the individual's solicitor on 9<sup>th</sup> November 2011. That individual availed of an opportunity to review relevant files from 2001 -2004 and further corresponded with the Inquiry



Team through his trade union on 8<sup>th</sup> February 2012. Arising from those representations, the Inquiry Team considered a written submission tabled by that individual on 16<sup>th</sup> February and had regard to that submission in finalising its report.

- 2.2.13. In the course of finalising its findings in January 2012, the Inquiry Team identified an administrative decision dating from mid 2007 which was unsupported by documentation on file. Accordingly, two additional HSE individuals were written to, inviting them to clarify the background and substance of that decision. The issue related to a lack of clarity around reporting relationships at [REDACTED] levels from mid 2007 – April 2008. Interviews were conducted with both individuals and as a result of those interviews, minor adjustments were made to the findings.

**2.3.      *Extension of Terms of Reference to consider issues raised by the birth mother (SUR1) with the HSE***

2.3.1.      Issues of concern were raised by SU1's birth mother (SUR1) in a letter to the HSE dated 26 June 2010. The HSE corresponded with SUR1 and suggested to her on 29 July 2010 that the Inquiry Team would address the issues raised in her correspondence as part of the ongoing process. SUR1 confirmed in a letter to the HSE dated 23 August 2010 and received 17 September 2010, that she was satisfied that her correspondence would be forwarded to the Inquiry Team for consideration as part of the ongoing Inquiry.

2.3.2.      The Inquiry Team wrote to SUR1 on 22 September 2010 inviting her to meet with the Inquiry Team and to outline a draft interim response to the concerns raised by her and to explain the context around that interim response.

2.3.3.      SUR1 did not respond directly to the letter of 22 September 2010 but on 20 October 2010 PD1 advised the Inquiry Team that she had spoken to SUR1 and had been advised that SUR1 would take up the offer of a meeting but would like to receive the draft interim response before arranging to meet with the Inquiry Team. In response, the Inquiry Team prepared a 21 page document which outlined the Inquiry Team's understanding of the interactions between SUR1 and the Health Board/HSE and vice versa. The Inquiry Team also summarised extracts from the files which were relevant to some of the questions raised by SUR1 but which were not associated with decisions which staff might be required to account for. This document was issued on 17<sup>th</sup> November 2010 and no response was received by the Inquiry Team to that document.

2.3.4.      The Inquiry Team wrote further to SUR1 on 8<sup>th</sup> February 2011 asking whether she could indicate whether she wished to further correspond with the Inquiry Team or whether she would take up the invitation to meet with the Inquiry Team. As no response was received to that letter, the Inquiry Team wrote finally to SUR1 on the 16<sup>th</sup> August 2011 advising that in the absence of any response from her, the Inquiry Team was not in a position to deal with the issues raised by her with the HSE.

## 2.4. ***Disclosures made under Part 14 of the Health Act***

2.4.1. The stated aim of part 14 of the 2007 Health Act is to encourage individuals within the Health Services to voice concerns regarding the safety and welfare of patients and to foster a culture of openness and accountability within the Health Services. In order to make a protected disclosure, employees of "relevant bodies" i.e. the HSE and those providing services on the HSE's behalf or those services receiving HSE assistance, are required to complain to an "Authorised Person" appointed by the HSE. The disclosure must be made in good faith and ...

- on foot of a reasonable belief that the health or welfare of a recipient of health care services is at risk
- the actions of a fellow employee are posing a risk to public health or welfare
- there is a failure to comply with a legal obligations
- there is a misuse or substantial waste of public funds
- there is a concealment or destruction of evidence

If the above criteria are fulfilled, the employee of the HSE or other relevant body is not liable for damages for making a protected disclosure, nor shall they be penalised by their employer for having done so.

2.4.2. The protected disclosures which are the subject of this Inquiry have as their background ongoing concerns in respect of the management of the care of a service user hereinafter referred to as SU1. Those concerns were the subject of discussions between the [REDACTED] disclosers and the HSE and the Department of Health and Children in September/October 2009. Those disclosers are hereinafter referred to as PD1 and PD2, one of whom is a [REDACTED] and the other a [REDACTED] [REDACTED] in a voluntary body providing a range of services to persons with an intellectual disability. The organisation is hereinafter referred to as ID1. The [REDACTED] disclosers were dissatisfied with the response of the Department of Health and Children to their concerns and notified those concerns by way of the Protected Disclosure Provisions of the Health Act to the

"Authorised Person" in November 2009. Arising from that disclosure, the Authorised Person arranged through the HSE for the establishment of an Inquiry Team to examine the concerns raised.

2.4.3. The second disclosure was notified to the Authorised Person in March 2010 by [REDACTED] hereinafter referred to as PD3, employed in the HSE LHO area with responsibility for service user SU1. The LHO area is hereinafter referred to as LHO1. That protected disclosure relates to documentation which PD3 had prepared summarising concerns in respect of service user SU1 and other service users who would have been placed in a foster placement/respite service, hereinafter referred to as SP2. Written material contained within that disclosure includes information and allegations relating to identified service users and their families. The Inquiry Team was not satisfied that adequate assessments were conducted in respect of those allegations prior to including detail in that documentation. For the above reasons this disclosure is not included in this Report or attached as an appendix to this Report.

2.4.4. The subject matter of both the November 2009 and March 2010 protected disclosures centres primarily on concerns relating to decision making around the care of SU1 and concerns about the appropriateness of the foster placement for SU1 and other service users. Accordingly the Inquiry Team has addressed the protected disclosures made through a comprehensive examination of key decision making around care and service delivery issues relating to SU1. The Inquiry has also sought to place on the record the known facts relating to concerns raised in respect of other service users who would have been placed in the foster care placement on either a residential or a respite basis. These are summarised in the Report and have been separately documented to the HSE.

### 3. Legislative and Regulatory Context

#### 3.1. **Background**

- 3.1.1. The Inquiry Team considered a range of legislative and regulatory provisions in place from 1989 until March 2010. In addition, best practice and policy frameworks applicable within the Health Services were also examined.

#### 3.2. **Child Protection Framework 1989- 1996**

- 3.2.1. Prior to the enactment of the 1991 Child Care Act, the Children's Act (1908) provided the main statutory basis for protecting children. The 1908 Act confined powers on the Courts to remove a child from parents or carers who had neglected or abused the child and to entrust the child to the care of a state agency or a fit person approved by the Court.
- 3.2.2. The Guardianship of Infants Act, 1964 defined "welfare of children" as comprising the "...religious and moral, intellectual, physical and Social Welfare."
- 3.2.3. The Department of Health provided guidelines on child abuse in 1987 but it was not until the publication of the Report of the Kilkenny Incest Investigation in 1993 that comprehensive guidelines were produced. Both the Eastern Health Board and the South Eastern Health Board introduced area specific child protection policies in the mid 1990s, in part, as a response to the Kilkenny Incest investigation and to the publication of the 1991 Child Care Act (which was not fully implemented until 1995). The 1991 Act extended the definition of "child" from age 16 and under to age 18 and under, and those provisions came into effect in 1995.
- 3.2.4. The South Eastern Health board introduced a comprehensive set of procedures for the investigation and management of cases of suspected child abuse in April 1996. That policy defined child abuse as including "...*physical abuse, sexual abuse, emotional abuse, and neglect.*" Neglect is defined as "...*failing to provide the love, care, food, or physical conditions including protection from danger, that will allow a child to develop normally. The neglect may be wilful or unintentional*". The definition further specifies examples of neglect including
- *Repeated accidents*
  - *Persistently hungry child*
  - *Poor school attendance*
  - *Continuing non attendance at appointments*

- 3.2.5. Clear provisions regarding responsibility for the investigation and management of child abuse are set out in the policy. These provisions include specific actions to be taken following disclosure of suspected abuse, such as;
- Notification procedures including notification to Gardai and Manager of Childrens Services and/or Senior Social Worker/Senior Public Health Nurse.
  - Provisions for a preliminary investigation.

The policy indicates that part of the preliminary investigation is to try and verify the information contained the notification and to assess the degree of risk to the child. If validation is deemed necessary, it is envisaged that provisions are put in place in place for attendance at hospital or at a "Community Child Centre"

The 1996 Policy also includes provision for an assessment of risk to be carried out and a guideline "scale of risk" Detailed provisions are also set out re the holding of case conferences and the generation of a "Child Protection Plan. The Policy provides for the identification of a Key Worker who is tasked to ensure that the protection plan is followed.

- 3.2.6. Where a risk is identified/ established, the potential options include assessing the risk to other children in the family and their need for protection.
- 3.2.7. In situations where it is concluded that there is no risk to the child, the Policy provides for three possible options
- Take no further action and close case
  - Refer child to another service
  - Draw up and implement a Treatment Plan for child/family

The Policy provides specific guidelines on factors which will influence a decision to close a case

- *Child free from abuse and developing adequately in physical and emotional bases*
- *Evidence of sustained stable and reasonably sound environment*

### 3.3. ***Adult Protection Framework 1996-2010***

3.3.1. The only formal available adult protection framework in the region where SU1 was placed was through the Protection of Vulnerable Adult Policy. The policy is discussed in detail in Section 6 below. The Inquiry Team has identified a

### 3.4. ***Foster Care Regulatory Framework***

3.4.1. The following three sets of Regulations governed SU1's foster placement and applied at different periods during her foster care placement from 1983 to 1996.

- **S.I. No. 101/1954 - The Boarding Out of Children Regulations 1954**
- **S.I No. 67/1983 – Boarding Out of Children Regulations 1983**
- **Child Care (Placement of Children in Foster Care) Regulations, 1995.**

### **S.I. No. 101/1954 - The Boarding Out of Children Regulations 1954**

3.4.2. These Regulations came into being on the 1<sup>st</sup> day of August 1954 and were revoked on the 1<sup>st</sup> day of April 1983. They governed the foster placement of a child until the child reached 16 years of age or for such a time as may have been necessary for the completion of the child's education.

In boarding out a child under these regulations the health authority had to be satisfied of the suitability of the child for Boarding Out, enter into a contract with the foster parent, receive from the foster parent a written recommendation from two reputable persons, arrange for the inspection of the child and of the house in which the child lived, ensure that not more than two children were boarded out with the one foster family unless all the children were from the same family, enter the child's name on a register, and

confirm that the foster parents had the same religious background as the child etc

### **S.I No. 67/1983 – Boarding Out of Children Regulations 1983**

3.4.3. These Regulations set out the procedures to be followed by health boards in boarding out children and prescribed the contract to be entered into by the foster parents. They contained the requirements as to the measures (including visits and reviews) to be taken by health boards to secure the welfare of such children. They also specified the records to be kept by the health boards. The Boarding Out of Children Regulations 1983 came into operation on the 1<sup>st</sup> day of April 1983 and were revoked on 31<sup>st</sup> of October 1995.

They governed the foster placement of a child until the child reached 16 years of age or for such a time as may have been necessary for the completion of the child's education. Under these regulations a health authority could not board out a child or leave a child boarded out in a home in which there are circumstances which, in the opinion of the health board might be detrimental to the health and welfare of the child.

The Regulations required the Health Authority to adequately prepare for boarding out. Foster parents were required enter into a contract with the Health Authority, furnish the health authority with two references, a medical report and have their home visited by an authorised officer of the health board. This visit was to determine that the foster parents were suitable in age and temperament, confirm the number and ages of other persons in the household and establish the suitability of the living and sleeping arrangements and other domestic conditions.

The Regulations also stipulated that the child be registered on the Register of Boarded Out Children, that each child would have a case record, that an inspection of the child and of the home in which the child lived was carried out to ensure the welfare and well-being of the child, that a review would be carried out to establish the health and well-being of the child, and that the minister of the child's religion was notified when the child was placed in their foster home.



### **Child Care (Placement of Children in Foster Care) Regulations, 1995.**

- 3.4.4. These Regulations came into operation on the 31<sup>st</sup> day of October 1995. They replaced the Boarding Out of Children Regulations 1983. The Regulations set out various requirements to be complied with by the health boards in relation to the placing of children in their care with foster parents, the supervision, visiting and review of children in foster care and the removal of children from placements, in accordance with the relevant provisions of the Child Care Act 1991.

The Regulations require that an assessment of foster parents takes place, references are provided, medical reports obtained, authorisation received to enable the Health Board to obtain statements from the Garda Síochána and confirm that the foster parents have the capacity to meet the needs of the child. They also require that a contract is signed, the religious wishes of the guardian are upheld, a care plan is prepared for the care and upbringing of the child, the child's name placed on a register, and a case record for the child put in place.

The regulations further stipulate that foster parents who are taking care of a child on behalf of a health board in accordance with these Regulations shall take all reasonable measures to promote the child's health, development and welfare. They require that children in a foster care arrangement are visited by an authorised officer of the health board and that the plan for the care and upbringing of the child is reviewed as often as may be necessary.

- 3.4.5. The Child Care (Placement of Children in Foster Care) Regulations, 1995 also govern the removal of children from placements either at the request of foster parents or termination of the placement by the health board
- 3.4.6. Compliance/ non –compliance with the above regulations in the foster care placements for SU1 are documented below in the body of this Report

#### **4. Background to the Issues Encompassed Within the Protected Disclosures Inquiry**

##### **4.1. Introduction**

- 4.1.1. This section summarises the key events and key decision making which impacted on the care of SU1

##### **4.2. SU1 – D.O.B. [REDACTED] Key events in the period 1978 to 1989**

- 4.2.1. SU1 was born in a maternity hospital to a single mother, hereinafter referred to as SUR1. It had been planned that the baby would be adopted but as the child was microcephalic, the intended adoption did not proceed. SU1 was discharged from the maternity hospital to a convalescent hospital in the spring of 1979. Files indicate that at least one attempt was made to secure a foster placement to no avail. SU1 was then admitted to a care setting for children for an intellectual disability in another Health Board area (HB1) in September 1979 and remained there for approximately three and a half years.
- 4.2.2. From February 1983 SU1's file shows evidence of significant activity around preparations being made for her fostering by a family in that Health Board area. The file indicates that references and medical reports in respect of the proposed fosterers were obtained in accordance with the Boarding Out of Children Regulations, 1983. The file also indicates that the prospective foster home was examined in line with the 1983 regulations.
- 4.2.3. In April 1983 SU1's birth mother (SUR1) consented to the foster placement taking place and approval was provided by the [REDACTED] (H1) of the then Community Care Area where SUR1 resided to the foster arrangement proceeding. H1 was the Children's Officer for the area where SUR1 resided. That area, which at the time was a former Health Board Community Care area, is hereinafter referred to as LHO1 and that area continued to be responsible for SU1. The fostering arrangement proceeded and boarding out contract was signed in August 1983.
- 4.2.4. Concerns in respect of SU1's development were notified in 1985 and there were a number of psychological and psychiatric reports and assessments carried out on SU1, both in

the Health Board area where the foster placement was based and when SU1 was placed in a school for children with an intellectual disability (ID4) for a period when one of the foster parents had been hospitalised. The files show that the [REDACTED] (H1) of LHO1 continued to liaise with other health professionals in respect of SU1's respite placement and in respect of her progress at school.

4.2.5. In April 1985 SU1 was returned to the foster parents, however the file noted that both of the foster parents were ill and that there were some concerns expressed by a [REDACTED] (undated) that there was a possibility that SU1 was being slapped on the legs. That month the [REDACTED] of the Health Board area where the foster placement was based advised the [REDACTED] that he was unhappy that SU1 had been returned to the same foster situation and would not accept responsibility for supervision of the placement.

4.2.6. Both the [REDACTED] H1 and the [REDACTED] H2 of LHO1 visited the foster care placement in the Health Board area and it was noted that the foster parents were distressed at the suggestion of a residential placement for SU1 and they expressed unhappiness at SU1's condition following her time in the respite placement (ID4). Approximately four months later a case conference was held to discuss SU1's placement and decisions were taken to continue placement under the supervision of the relevant Health Board (HB1), but that it was envisaged that long term care for the service user would be provided by the Health Board (HB3) where the birth mother was originally domiciled.

4.2.7. From September 1985 until the end of 1986 the files show evidence of regular monthly visits and assessments being carried out by the [REDACTED]. Those reports indicate that SU1 was attending school, was well groomed and happy, and well cared for. However in December 1986 the foster parents informed the [REDACTED] that they had interpersonal problems and the following month a psychiatrist in HB1 advised the [REDACTED] in LHO1 that the foster parents were about to separate and that the foster mother had asked for custody of SU1, and this appears to have been conceded to on a trial basis of six months.

4.2.8. For the duration of 1987 and 1988 SU1 continued to be placed with one and then both of the foster parents following a brief reconciliation between the couple. The [REDACTED]

visits during that period report that SU1 was clean, tidy, well groomed. Difficulties began to emerge however in 1989.

4.2.9. In January 1989 it was discovered that because the foster mother was suffering ill health, there were times when SU1 was being looked after by a neighbour and this led to a case conference being called and, following that case conference, the acting [REDACTED] in the Health Board area (HB1) stated that he was no longer in a position to provide foster care. [REDACTED] (H1) noted on file that short term foster care would be sought for SU1 along with longer term residential accommodation within the Health Board area (HB3) where the birth mother was originally domiciled. The [REDACTED] notified HB1 that she would collect SU1 on 22 February for transfer to a temporary foster placement.

#### 4.3. ***Key events in the period 1989 – 1996***

4.3.1. The files indicate that on [REDACTED] 1989 a copy of a Form of Contract for Child Boarded Out was signed by foster mother [REDACTED]. This was in accordance with the Boarding Out of Children Regulations 1983. The following month the former foster mother stated that she was now medically fit to have SU1 returned to her but this did not occur and the [REDACTED] proceeded to notify the former foster parents that a new placement had been located. It is also noted on file that the new fostering arrangements would be in place until a residential place was made available for SU1. It was also noted that SU1 was on such a waiting list (in ID5).

4.3.2. It was noted in September 1989 that arrangements for psychiatric and psychological assessments would be required as well as a need for day services for SU1. That month the [REDACTED] visited the placement and praised the location and the foster parents ([REDACTED]) while posing the following questions about the placement including:

- A lack of other children for SU1 to socialise with within the home
- The age of the foster father ([REDACTED])
- The fact that SU1 was not attending school

- 4.3.3. In December 1989 there is correspondence on file from the [REDACTED] (H1) to the new foster parents informing them that a place had been reserved for SU1 from the middle of that month to attend school in ID5, which was in the same county as the foster placement.
- 4.3.4. There is no evidence on file that the foster parents or the placement was assessed at any level as required under the Boarding Out of Children Regulations 1983, or that references were obtained as per those regulations. There was no evidence of a documented visit by the Health Board to determine the suitability of the home environment prior to the placement as provided for by the regulations. There is no documented first two month visit as required under the regulations. There are, however, references in H1's diary to seven visits to the placement in 1989.
- 4.3.5. The next reference to SU1 on file is almost one year later in November 1990 where following a visit by the [REDACTED] around that time, it was noted that SU1 had not been recalled back to the school after Christmas 1989. It was also recorded that the foster parents appeared quite happy with that situation. There is a reference at a later stage in the file from the [REDACTED] that SU1 did not attend school due to transport problems.
- 4.3.6. There are no documented six monthly reviews as required under the Boarding Out of Children Regulations 1983 and no evidence that efforts were made to deal with whatever obstacles were encountered including transport difficulties which were preventing SU1's attendance at school.
- 4.3.7. There is no evidence on file for 1991 of six monthly review visits as per regulations and no reference to any ongoing efforts to accommodate SU1's school needs.
- 4.3.8. In 1992 the files show evidence of the [REDACTED] requesting a residential placement for SU1 from a residential facility (ID3) located in the birth mother's home town. There is also evidence of a medical report being sought from the relevant [REDACTED] (H3).
- 4.3.9. There is no evidence on file of any activity around SU1 for 1993 and no documented review visits as per the Boarding Out of Children Regulations 1983.
- 4.3.10. There are brief handwritten notes on file indicating two possible home visits in 1994, one on 13 February and one on 17 June. There is no evidence on file of any documented review

visit as per the Boarding Out of Children Regulations 1993. It should be noted that the designated Fostering Social Work Service was introduced in the Health Board Area in 1994.

4.3.11. The files indicate a significant round of activity around SU1 in 1995 which may have been as a result of a visit to the placement by the [REDACTED] to "Parents of Mentally Handicapped" (H4). There followed a medical report by the Area Medical Officer, and a request for a consultation with an Ophthalmic Physician.

4.3.12. The 1995 file also indicates that the [REDACTED] (H3) sought a residential placement for SU1 in an area outside of the immediate Health Board and the file notes that this request was due to the foster parents "becoming elderly".

4.3.13. In May 1995 the file shows that a psychological assessment was carried out on SU1 and concluded that SU1 continued to function intellectually within the profound range of learning disability. The report also observed that SU1 had not made obvious gains intellectually or in terms of self care skills since her previous assessment in 1989. Although the report stated that SU1 was a "highly dependent teenager" it stated that she appeared to be "content". With regard to recommendations for future placement, the report stated that SU1 would require full time care to cater for her basic needs and that she would benefit from regular attendance at a day care facility from the point of view of extra stimulation and social contacts. This report resulted in a letter of application being made by the [REDACTED] (H4) for a day service.

4.3.14. In July 1995 the file notes that the [REDACTED] requested [REDACTED] H8 to arrange for the following:

- I. a day placement in (ID1 day services)
- II. a request for residential placement at (ID3)

4.3.15. The file notes state that there was a home visit by the [REDACTED] (H8) and the N [REDACTED] (H4) and that SU1 "appeared very well and happy". Following a further home visit in August 1995 it was noted that the foster father Mr. [REDACTED] did not agree to SU1 going to a "workshop" as "there was nothing could be done with her". Nonetheless the foster parents met with the [REDACTED] and the [REDACTED] (SP1). Following this meeting SU1 was accepted for day services and transportation and admission dates were to be addressed.

4.3.16. The file indicates that SU1 commenced in the day service on 4<sup>th</sup> September 1995. On 12 September 1995 the [REDACTED]

[REDACTED] noted that SU1 had settled in well and had her eyes checked and had glasses prescribed. There is no indication on file of any concerns in respect of frequency of SU1's attendance at day services in 1995.

4.3.17. In the course of a home visit by the [REDACTED] accompanied by the [REDACTED] to the [REDACTED] on 17 October 1995 it is noted that [REDACTED] that SU1 was taking off all her clothes when she got home in the evening. It is also noted that Mrs [REDACTED] claimed that the [REDACTED] H1 and the [REDACTED] H8 had promised her that SU1 would remain with the [REDACTED]

4.3.18. The file includes an incident report form from the day service dated 19 October 1995 which states as follows ... "While toileting [SU1] in the am, large bruise noticed on left hip, appears tender to the touch. Bruises noticed also on left elbow and right elbow just visible and not tender to touch. In good form"

4.3.19. The file includes an incident report from the day services dated 25 October which states that "for the first time in [day services] while on social programme training... [SU1] completely stripped herself for no apparent reason, notified previously of these stripping incidents at home by [REDACTED] [REDACTED] H4]

4.3.20. An undated report from the day services signed by the day services manager (SP1) on file, produced seven months after her admission to day services detailed "chaotic behaviour on admission" and reported her eating habits in the dining room where she would "wolf" down her dinner and then steal the dinners of others around her and that she took to "head-butting" other trainees. This report also noted that SU1 took to stripping off all her clothes both on the bus and at the day service. The report also noted that following seven months of constant supervision that such behaviours were no longer manifested. The report further notes that "*on several occasions when she was being bathed at our centre, bruising was noticeable on her body. These bruises were brought to the attention of her foster parents, they informed us that they couldn't account for these bruises and said they must have happened when she was on the bus.*" It should be noted that the only incidents on file from day services from that period are those referred to in paragraphs 3.3.18 and 3.3.19 above.

4.3.21. There is no evidence that the bruising reported in the day services was investigated other than being informally addressed with the foster parents.

4.4. ***Key events in the period January – December 1996***

- 4.4.1. 1996 is a key year in respect of decision making around the care of SU1. 1996 also includes associated activity following disclosure of reported abuse by the mother of a service user (SU2) resident in the UK. The abuse was stated to have occurred while the service user was attending a foster placement with the [REDACTED] on respite. This disclosure would appear to have triggered a significant amount of activity in respect of SU1's placement in the same foster setting.
- 4.4.2. The file indicates that in January 1996 there was a home visit by the [REDACTED] H4, accompanied by the [REDACTED] (H5) to ascertain the [REDACTED] understanding of the need to place SU1 in a residential setting.
- 4.4.3. In March 1996 contact was made by a UK based social worker from a regional Social Services Department (UK1). A letter had been forwarded to UK Social Services from the mother of service user SU2 (date of birth 11.1.74). That letter alleged that her daughter had been sexually molested when her daughter had spent a week on holiday/respite with the [REDACTED]. The mother and daughter were residing in LHO1 at that time. A summary of the known facts surrounding the processing of this matter by LHO1 and the relevant Health Board (HB3) is set out below.
- 4.4.4. The disclosure from the UK in March 1996 led to a notification meeting taking place between relevant Health Board professionals on 2<sup>nd</sup> April, including the [REDACTED] (H6), the [REDACTED] (H7), and the [REDACTED] (H3). That meeting is recorded as arriving at the view that they would seek an alternative placement for SU1 and that the reason for seeking such alternative placement was based on ongoing issues in respect of the age and ill health of one of the [REDACTED] and in light of the UK allegation, that reasonable steps had to be taken to protect SU1. Within a week arrangements had been made to secure a residential bed in ID10, a residential facility for persons with an intellectual disability within the Health Board but in an adjacent LHO area.
- 4.4.5. The [REDACTED] were met by the [REDACTED] (H6) and the [REDACTED] (H4) and they were advised that the Health Board was now in a position to place SU1, who was now seventeen years of age, in a residential setting appropriate to



her needs. Mr [REDACTED] was also advised of the UK complaint, which had specifically made serious allegations against him.

4.4.6. The [REDACTED] were advised on 22<sup>nd</sup> April of their right to make representation to the Health Board under the 1995 Child Care Regulations. Those regulations provided for an opportunity to be made for foster parents to make representations to the Health Board where they made objections to proposals to remove a child from their custody.

4.4.7. On 23<sup>rd</sup> April a case conference was held in LHO1 attended by all of the relevant professionals with the exception of the [REDACTED]. There is no record of a representative from the ID1 Day Services being invited to take part. There is no indication in the minutes of the case conference of the date of birth of SU2. At that point SU1 had been in attendance at Day Services for approximately seven months. The case conference was advised by the [REDACTED] (H4) and [REDACTED] (H12) about concerns about SU1's behaviour in the "workshop" (Day Services) and reported the incidence of pulling hair, eating other service users' food, poor personal hygiene and incidents of SU1 stripping off her clothing on the bus home. It was also reported that there were concerns that *"SU1 was reverting to her former agitated behaviour"*. Other than the written report from Day Services referred to in 1.3.20 above, the file is unclear where such information was derived from. It should be noted that there is no indication in the report from Day Services that SU1 was reverting to her former alleged behaviour. That report states *inter alia...*

*"Overall SU1 has made remarkable improvements. Gone are the days of containment. We have progressed to the stage of introducing her to outdoor activities like swimming and bowling. These have been successful to date. She also goes on a daily walk. She now presents no problems to other trainees. Obviously after confinement at home, she was unaccustomed to dealing with an environment like ours. She now appears more happy and content with herself"*.

4.4.8. The purpose of the April 23<sup>rd</sup> case conference was to discuss the allegations re SU2 which had come from the [REDACTED]. Discussion did take place around the suitability of the [REDACTED] placement and it was noted that the [REDACTED] would be appealing the decision to remove SU1 and it was agreed that they would await the outcome of that process, which was described as an "appeals board", before proceeding with SU1's removal from the [REDACTED]. The case conference also decided to compile a list of

children placed by the Health Board and placed privately with the [REDACTED] between 1983 and 1988. The case conference either noted or decided that the Health Board was no longer using Mr. [REDACTED] and Mrs. [REDACTED] as foster parents.

4.4.9. The file indicates that Mr. [REDACTED] wrote to [REDACTED] H8 on 24<sup>th</sup> April requesting that they be given time to get their grandson accustomed to SU1 leaving the placement and suggesting that they retain SU1 until "the Autumn". That letter also indicated that the [REDACTED] understood the reasons for wanting to remove SU1 from the placement. There is no record of that letter being responded to or being further discussed by the professionals involved in decision making around the removal of SU1 from the placement.

4.4.10. Two professionals from outside of the LHO1 were appointed to hear representations by the [REDACTED] in respect of the removal of SU1 from their care. One of the professionals was the [REDACTED] from an adjoining LHO area within the Health Board (H9). There were no evident terms of reference established for this process and no indication as to who these professionals would issue their report to. The second professional had a regional Child Care Development role (H10). Those professionals met with the [REDACTED] to hear representations on Friday, May 17<sup>th</sup> 1996. A minute of that meeting recorded the arguments put by the [REDACTED] for the retention of SU1 in their care. There is no record of a repeat of the suggestion made in Mr. [REDACTED] letter of 24 April and no discussion around that suggestion (i.e. that the removal of SU1 would be deferred until Autumn 1996). The minutes recorded that the following questions required to be clarified from the meeting:

- I. "was (SU1) reviewed during the course of her placement and were Mr. [REDACTED] and Mrs. [REDACTED] aware that alternative placements were being explored for (her)"
- II. "at what level did discussions take place in relation to moving (SU1) to an alternative placement"
- III. "what reasons were given to Mr. [REDACTED] and Mrs. [REDACTED] in relation to the proposed move"

The Inquiry Team is unable to establish how the above questions were followed up and there is no record available on file indicating that these questions were followed up and no record on file as to any decision or recommendation made by the two professionals having heard the representations.

4.4.11. The next record on file in respect of the representation process is a letter dated 9<sup>th</sup> August 1996 which Mr. [REDACTED] had

written to the Minister for Health and had been copied to the Health Board. That letter stated that the [REDACTED] had "lost the appeal" and appealed further to the Minister to "decide in their favour". On receipt of this correspondence the Department of Health requested a report on the matter from the Health Board on 15<sup>th</sup> August 1996. The [REDACTED] (H11) responded on 20 August 1996 and advised that the matter was being dealt with under Section 43 of the Child Care Act and that the Health Board... *"..have grounds for believing that it is in the best interests of the child to be removed from its current child care placement"* The letter also states that the foster carers objections had been heard as per regulations and that the proposed plan to remove SU1 to the residential placement ID3 was going ahead following... *"an agreement to leave her with the family for the summer"*. (There is no record on file of any such agreement other than Mr. [REDACTED] request on 24 April 1996). The Inquiry Team understands that at some point a decision was taken to fill the bed left vacant for SU1 from April that year (in ID10) on the basis that a placement would be available for SU1 in ID3 at the end of that summer. There is no indication on file as to what forum this decision was taken in and no record of that decision.

4.4.12. On 26 August 1996 the Minister's office received a letter from the principal of the local school attended by the [REDACTED] grandson, in support of the [REDACTED] retaining SU1 in the placement. This letter was furnished by the Department of Health to the Health Board on 11 September 1996 with a request for report on the matter. H11 responded on 25 September 1996 explaining that the matter was *"...currently under consideration by the professional staff on the board"* and that the school principal's view would be taken into account in *"...reaching their recommendations in relation to future care of (SU1)"*.

4.4.13. There is a reference on file to a professionals meeting on 6<sup>th</sup> September 1996 which is also described by one of the interviewees. That professionals meeting reportedly planned for a home visit to inform the [REDACTED] of the residential placement being allocated. The home visit took place on 12<sup>th</sup> September and it is recorded that the [REDACTED] stated that they would oppose SU1's placement in residential care and stated that they had written to the Minister.

4.4.14. Between 12<sup>th</sup> September and 24<sup>th</sup> October the available files do not give an account of activity during this period. There is however a note dated 26 September 1996 drafted by the [REDACTED] which appears to be on the basis of a discussion with the [REDACTED] for the District where

the [REDACTED] resided. This note gives an account of the identity of individuals understood to be residing on the property of the [REDACTED]. It is also noted that Mrs [REDACTED] works away from the house and that the children including SU1 would be cared for by her nephew while Mrs [REDACTED] was at work. (It should be noted that the 1995 Child Care Regulations state that foster parents shall in particular make good and proper arrangements for the care of the child in the case of absence of the child or both of the foster parents from the foster home). On the basis of the interviews undertaken it is reported that the following actions were taken during that period:

- The question of the removal of SU1 continued to be discussed at weekly notification meetings and on an ongoing basis between the professionals involved.
- That there were reports of decisions being taken to consult with the Health Board's legal advisors, particularly a solicitor identified in this report as LA1. There is nothing on record to indicate the nature of any advice sought or received. The Inquiry Team has established from the firm of solicitors in question that it has no records relating to this matter from 1996.
- There is some dispute in recollection between the professionals as to whether a decision was taken not to remove SU1 prior to the case conference held on 24<sup>th</sup> October 1996. There is also a dispute as to why the decision to remove confirmed at the case conference in April 1996 was effectively overturned in October 1996. The [REDACTED] (H7) is of the view that the decision was taken at the case conference while the [REDACTED] (H6) was of the view that the decision not to remove was because "*the appeal*" by the [REDACTED] was successful.

4.4.15. The purpose of the 24 October 1996 case conference was stated to have been *"to discuss (SU1's) continued placement with the [REDACTED] following the investigation made into allegations against (Mr [REDACTED])"* (The Inquiry Team notes that there was no substantive investigation or outcome in respect of the complaints made against Mr [REDACTED] in respect of SU2, resident in the UK) The case conference noted that the [REDACTED] were offered shared care with the residential placement which had been declined and noted that legal advice had been sought regarding SU1's removal from the [REDACTED]. It was also noted that *"there is no evidence that anything happened to (SU1) or that her well being or welfare are not being met by (the [REDACTED])"* The case conference further noted that neither the Health Board nor another Intellectual Disability Service Provider (ID2) would be placing further children with the [REDACTED]. The following recommendations were made by the case conference:

1. *"(SU1) will not avail of the residential placement in (ID3). Dr. (H3) [REDACTED] will inform (ID3) of this and (SU1) will go back on the waiting list"*
2. *(SU1) to remain in her current placement with (Mr [REDACTED] and [REDACTED])"*
3. *Any change in her circumstances will be reviewed.*
4. *[REDACTED] (H7) to inform (Mrs. and Mr. [REDACTED]) of the outcome of the case conference*
5. *(H3 [REDACTED]) to introduce ([REDACTED] H12) as the new Key Worker, now that (SU1) is an adult.*
6. *[REDACTED] H12) to discuss with (LA1), solicitor, the procedure to make (SU1) a Ward of Court*
7. *[REDACTED] H12) to attempt to contact (SU1's) natural mother in England to inform her of (SU1's) position.*
8. *(H3 [REDACTED]) to check with the [REDACTED] (ID1 Day Services) that (SU1) can remain in her placement there"*

4.4.16. On 14 November the [REDACTED] (H3) visited the [REDACTED] and advised them that SU1 would be remaining with them and that the residential placement in ID3 had been cancelled and SU1's name put back on the regional waiting list. Mrs. [REDACTED] was also advised that as SU1 would be eighteen on 24 November 1996, the fostering allowance would be cancelled.

4.4.17. On 20<sup>th</sup> November the Acting [REDACTED] (H7) wrote to the [REDACTED] confirming that as SU1 had now reached eighteen years, [REDACTED] (H4) and the Foster Care team would no longer be involved in SU1's care. The letter further advised that the [REDACTED] (H3) would make an appointment to meet to discuss changes and to arrange the introduction of staff attached to the "Adult Mental Handicap Service". On that

same date the [REDACTED] wrote to the newly appointed [REDACTED] (H29) and advised as follows:

*"...In October 1996 a place became available for (SU1) in a hostel within the Mental Handicap Services provided by the (ID3). (Mr. and Mrs. [REDACTED] again indicated to [REDACTED] (H3) that they wished to continue to care for (SU1) for a further four to five years and did not wish to avail of the residential care placement.*

*Following consultation with [REDACTED] (H10) and (LA1) solicitor, and a further case conference, it was decided not to proceed with removal of (SU1) under Section 43 of the Child Care Act. She will continue to live with the [REDACTED] family for the present time with regular review of the situation by the Adult Mental Handicap Service. It was also decided to explore the possibility of making (SU1) a Ward of Court. (SU1) has no family in this country. She was in voluntary care of the Health Board and her mother does not want to have any contact with her."*

#### 4.5. **Key Events in the period 1997 – 1999**

4.5.1. The responsibility for SU1 transferred from the Foster Care team to Adult Mental Handicap Services with [REDACTED] (H12) designated as Key Worker. A joint home visit to the [REDACTED] took place in February 1997 where the [REDACTED] (H3) introduced the [REDACTED] to the F [REDACTED]

4.5.2. The [REDACTED] (Mr. SP1) telephoned the Health Board notifying that SU1 had been home with a cold from 24<sup>th</sup> April until 12<sup>th</sup> May and expressed concern about the length of time she had been absent. It was further noted that SU1 returned to Day Services on the following day.

4.5.3. The file indicates that there was some discussion around contacting SU1's natural mother and that some attempt was made to telephone the former [REDACTED] (H1). [REDACTED] (H12) visited the [REDACTED] on the 1<sup>st</sup> June 1997. Following that visit the [REDACTED] produced a number of file notes including one of the home visit and one of a telephone call with the former [REDACTED] (H1), who provided some detailed background. The file note records that the former [REDACTED] (H1) felt that SU1 was not appropriately placed because of the advancing age of the carers. It was also noted that there was a lack of stimulation for SU1 and that a residential placement would be more appropriate. The note further states "If (SU1's) natural mother would give written consent to place her daughter in more appropriate setting – this should override

*wishes of Mr. [REDACTED] and Mrs. [REDACTED] or Wardship – High Court would make decisions. Visit to mother in London may be required."*  
There is no evident follow up arising from that note.

4.5.4. In June 1997 the [REDACTED] (H12) began job sharing with [REDACTED] (H13). Although there is no indication on file, H12 indicated that H13 took on responsibility for SU1. H13 has indicated that on her week on she alternated between Adoption and Disabilities. H13 has indicated to the Inquiry Team that she was not aware of SU1 being a priority case and was unaware of decisions from the case conference regarding the possibility of making SU1 a Ward of Court. There is no evidence on file of a documented handover between the [REDACTED] (H12 to H13). Nor is there any documented follow up of the actions agreed upon by the October 1995 case conference re SU1.

4.5.5. There is no reference on file of any activity relating to SU1 from June 1997 until 1998. There is a suggestion from ID1 Day Services that it advised the Health Board that SU1 had sustained a black eye at some point in 1998 but there is no evidence on the Health Board file of this. Apart from this suggestion, there is no other activity recorded for SU1 for the entire period of 1998.

#### 4.6. **Key Events in the period 1999 – June 2001**

4.6.1. In early 1999 there is a note of a telephone call from H15 to ID1 Day Services and it was reported that SU1 was out sick. This facilitated a home visit by (H13) on 20 January 1999. The [REDACTED] advised that SU1 had gum disease and that this had been discovered following a visit to their GP. It was noted that the incoming [REDACTED] (H14) would visit along with H13 on an unspecified date.

4.6.2. The period from the appointment of [REDACTED] H14 to [REDACTED] in March 1999 until her departure in June 2001 featured a significant level of activity and intervention relating to SU1. H14 filled the post on a part time basis opposite [REDACTED] H12, who was the original identified Key Worker for SU1 arising from the October 1996 case conference. The total staff involved in Disability Services in LHO1 at the time consisted of the two job sharing [REDACTED] the [REDACTED] [REDACTED] H4 and a [REDACTED]. It is noted that the incoming [REDACTED] H14 has indicated that SU1's case was identified as a priority but "*not top priority*".

4.6.3. As part of the preparations for taking up duties in Disability Services, the file notes that [REDACTED] H14

contacted ID1 Day Services and learned of significant concerns re SU1 from the [REDACTED] SP1. These concerns included:

- SU1's many absences from Day Services
- Attempts to remove SU1 from foster care in 1996 but still remaining in the placement
- Pattern of SU1 when returning from long absences being discovered to have marks/bruises but that explanations for these would have been provided by the [REDACTED]
- That over a year previously, SU1 had presented with a black eye but that Mrs. [REDACTED] insisted that it hadn't happened at home
- That SU1 was being closely monitored and if there were concerns felt that Social Workers would be notified
- That the [REDACTED] of the Day Services recommended future placement for SU1 in a residential setting

4.6.4. Both [REDACTED] H14 and H13 conducted a home visit to the [REDACTED] on 19<sup>th</sup> March 1999 where it is noted that discussion took place around possible future services for SU1 including weekend/holiday or respite care breaks leading to residential placement in ID3 to cater for SU1's eventual long term needs being met. The record notes Mrs. [REDACTED] being tearful and upset and advising the [REDACTED] that there had been a previous attempt to remove SU1 to residential care but the [REDACTED] had appealed this decision and Mrs. [REDACTED] understood that SU1's name was now on a waiting list for residential care in the event of the [REDACTED] being unable to continue to care for SU1. It is further noted that [REDACTED] advised the [REDACTED] that it was the [REDACTED] role to consider what would be in SU1's best interests and that the case would be under review.

4.6.5. The next file entry in respect of SU1 relates to 23 July 1999 when H14 made application to Residential Service ID3 to continue SU1's name on the waiting list. H14 wrote to SU1's birth mother at the last known address in London following noted attempts in days previously to contact her by telephone. A further telephone call was made in August 1999 without reply and efforts then made by social work staff to verify contact details through the District Public Health Nurse for the area where SU1's birth mother originally lived in LHO1.

4.6.6. On 9<sup>th</sup> August 1999 [REDACTED] H14 advised H15 that the Residential Services were interested in providing respite for SU1 by way of assessment for suitability for their service at some point that month. This resulted in a request being made



for [REDACTED] H14 to contact Residential Services, the [REDACTED]s and the natural mother on this.

4.6.7. There is a record on 31 August 1999 of [REDACTED] H14 telephoning the [REDACTED] of ID1 Day Services to enquire of SU1. The [REDACTED] described SU1 as "well, nothing untoward, attendance good". The [REDACTED] of ID1 Day Services also described Mrs. [REDACTED] as "over protective" and stated that SU1 "goes home, goes to bed, never attended school". D14 advised the [REDACTED] of DS1 that Mrs. [REDACTED] had been encouraged to allow SU1 more independence and that efforts were being made to contact SU1's birth mother. The last known Irish address of the birth mother, SUR1, was visited on 25<sup>th</sup> August 1999 but contact details for the birth mother could not be obtained. Further efforts were made through the Community Welfare Officer Service to obtain such details and contact was made between the CWO and the birth mother's sister, but she was unwilling to give him the birth mother's address but indicated that she would contact the [REDACTED] directly. In the absence of any such contacts, H14 wrote to the sister who was still resident in LHO1, requesting that the birth mother contact her. The letter referred to SU1 by name and was signed by H14 in her role as [REDACTED]

4.6.8. On 20<sup>th</sup> September 1999 the birth mother made telephone contact in response to the letter to her sister. She expressed her concern about the proposed residential placement in ID3 as it is situated near her original home. The file note records that "she is not altogether opposed to the idea." There is also a note that as SUR1 had not seen her daughter (SU1) since she was a baby, she would like to receive some photos of her.

4.6.9. On 27 September 1999 D14 telephoned the birth mother SUR1 to discuss the proposed plan to place SU1 in residential care. SU1's birth mother agreed, with some reservations, with the Health Board's plan for long term residential care for her daughter. Following this, D14 made a home visit to the [REDACTED] on 30 September to notify them of her discussion with SU1's birth mother and that the mother was in agreement with the Health Board's proposal to place SU1 in residential care. Mrs. [REDACTED] was noted as being opposed and upset at the suggestion. The [REDACTED] H14 also asked to meet with Mr. [REDACTED] and the file note records that Mr. [REDACTED] who at that point had been diagnosed with Parkinsons Disease, was shaking uncontrollably and became agitated and verbally abusive about the Health Board and about the [REDACTED]. It is noted that the [REDACTED] had raised the 1996 UK allegation with Mrs. [REDACTED] and that Mrs. [REDACTED] brought

this to the attention of Mr. [REDACTED] Mr. [REDACTED] response is recorded as stating that there was no truth in that allegation and that he suspected the Health Board (HB3) had fabricated the complaint as he had not been given the name of whomever made the allegation and he also stated that it had been dealt with "*by a tribunal and dismissed*". The file also noted that Mrs. [REDACTED] stated that SU1 would have to be removed forcibly. Mr. [REDACTED] is recorded as advising the [REDACTED] (H14) to come back in five years time. The visit is stated to have concluded that Mrs. [REDACTED] would agree to think about what was discussed and Mrs. [REDACTED]'s final position suggested that she would only accept SU1 moving if the birth mother put it in writing that she no longer wished her to stay with the [REDACTED]. The Social Worker noted a well kept and clean appearance re SU1. There are no further file notes re SU1 for the remainder of 1999.

4.6.10. On 2<sup>nd</sup> February 2000, [REDACTED] H14 wrote to the birth mother indicating a plan to move SU1 gradually from the current placement starting with a two week assessment period followed by regular respite breaks. The letter indicated that the plan also included moving toward a weekly placement in residential care in ID3 with the option of returning to the [REDACTED] at weekends. The letter noted that Mr. [REDACTED] and Mrs. [REDACTED] were not prepared to accept this without written permission from SUR1, the birth mother.

4.6.11. On 3<sup>rd</sup> February 2000, a file note indicates that Mrs. [REDACTED] had told staff at Day Services that SU1's teeth would be removed. It is further noted that the [REDACTED] (SP1) would invite Mr. [REDACTED] and Mrs. [REDACTED] to meet with him to discuss future plans for SU1. The file also indicates that the [REDACTED] (SP1) was informed of the previous attempts to contact the birth mother and around the application for residential placement at ID3. There is also a note of a request to send a photo and profile of SU1 as Mrs. [REDACTED] had been requested to do so and this had not happened. A profile and photograph was subsequently prepared by the Day Services dated 27 November 2000.

4.6.12. There is no further activity evident from the files until 7<sup>th</sup> November 2000 when the then [REDACTED] [REDACTED] (H15) issued an internal memo stating that a residential placement would be made available to SU1 by ID3 in April 2001 and asked that the required consent be obtained and SU1 prepared for the transition to a new service. This memo was followed by a letter from [REDACTED] H14 to the birth mother on 16<sup>th</sup> November 2000. This letter notified her that there was a residential placement available from 2001 and that

written permission had been requested the previous February in order to obtain agreement of the [REDACTED] Assurances were provided in respect of confidentiality of correspondence to the birth mother and concluded that the Health Board personnel involved with her daughter's welfare strongly recommended that it would be in SU1's long term best interest to secure her future in a long term residential placement which had now become available to her. This letter was followed by a phone call to the birth mother by [REDACTED] (H14) where the birth mother is reported as stating that she hesitated to reply to the letter earlier that year requesting consent to transfer SU1 to residential services.

4.6.13. [REDACTED] H14 again corresponded with the birth mother on 7 December 2000 attaching a profile and photograph of SU1, as well as details of the Day Services. The letter also reminded the birth mother of the request for written permission for the residential placement. Further correspondence in December was forwarded to the proposed residential placement providing background and reports on SU1 and advising that written consent was being awaited from the birth mother. At some point in December the birth mother signed the consent form in respect of SU1's transfer to residential care.

4.6.14. [REDACTED] H14 convened a professionals meeting which took place on 22<sup>nd</sup> February 2001 and which was attended by a range of professionals including the previous [REDACTED] H6 who would have been involved in decision making around SU1 in 1996. The [REDACTED] of the ID1 Day Services also attended. The minutes of the professionals meeting noted that the former [REDACTED] H6 stated that with regard to the previous case conference held on 24<sup>th</sup> October 1996, she advised that:

*"...Previous allegations were dealt with and cannot now be resurrected as grounds to justify any decisions made in relation to planning for (SU1's) long term care. (SU1's) present circumstances and long term best interests need to be assessed independently."*

The professionals meeting also heard reports from the [REDACTED] Day Services re SU1 around her frequent absences for long periods in her early days and her regression when she returned from periods away from Day Services. The [REDACTED] also reported that the [REDACTED] never availed of respite care and SU1 had never been sent on the annual holiday arranged by the Day Service. A profile was also provided of the [REDACTED] including their age and Mr. [REDACTED] illness. The recommendations of that meeting are as follows:

1. "A phased plan to be put in place to enable the [REDACTED] to gradually relinquish the full time care of (SU1)
2. To encourage opportunities for (SU1) to socialise and integrate with her own peer group
3. Encourage the [REDACTED] to allow (SU1) to avail of respite care i.e. one night away in (ID1 Respite Service), a week's holiday in the summer arranged by (ID1 Day Services)
4. Introduction to other parents through the local Associate of Mental Handicap to support the [REDACTED] through separation. Explain the process the process of moving and how this will affect benefits/allowance. Disability Allowance will only be fully relinquished when (SU1) goes into full time residential care
5. Work towards relocating (SU1) to (ID3's) workshop day care
6. (ID3 Residential Care) Monday/Friday. Home weekends. Foster parents would receive a proportion of Disability Allowance
7. Home Support Worker to be discussed with (Mrs. [REDACTED])
8. Reviews to be held to monitor the progress. If no movement by January 2002, Health Board to consider legal action e.g. Wardship.

4.6.15. The outcome of the February professionals meeting is reported as having been communicated by [REDACTED] H14 to Mrs. [REDACTED] by way of a telephone call on 23 February 2001. In the course of that telephone call Mrs. [REDACTED] advised that Mr. [REDACTED] died the previous June. It is noted that Mrs. [REDACTED] stated that she depended on the placement for income and arrangements were made by the [REDACTED] (H14) to conduct a home visit. On that same date H14 contacted the [REDACTED] (H5) who had undertaken a visit to the [REDACTED] on that date. It was noted that SU1 had been at home that day as it reported by Mrs. [REDACTED] that SU1 had been banging her head on the bus. The [REDACTED] is reported as stating that she had no concerns about SU1's care except for commenting that she seemed "thin". The [REDACTED] confirmed that she was aware of Mr. [REDACTED] death the previous June but had not advised the [REDACTED] [REDACTED] with responsibility for Disabilities (H4) as she had thought that this would have been done through the ID1 Day Services.

4.6.16. On 27<sup>th</sup> February 2001 there is a file note of a telephone call between [REDACTED] H14 and the [REDACTED] S [REDACTED] SP1. It is noted that SP1 is reported as stated that he was surprised that Mrs. [REDACTED] had not referred to the death of her husband in any of her contacts with the Day Services or through the local Mental Handicap Association.

4.6.17. [REDACTED] H14 visited the [REDACTED] home on 27 February 2001 and the [REDACTED] noted that Mrs. [REDACTED] restated that she relied on the income that caring for SU1 brought into the home and requested that they would like SU1 to remain with them (her and her grandson) until her grandson was eighteen years of age, i.e. in five years time. Mrs. [REDACTED] reported as declining the offer of home support and that Mrs. [REDACTED] stated that she had discussed the position of SU1 with her own solicitor and would be contacting the birth mother to get permission for SU1 to stay another five years with her.

4.6.18. A further professionals meeting was held on 21<sup>st</sup> March where Mrs. [REDACTED] request to be allowed to continue to care for SU1 for a further five years was discussed as was the issue raised by Mrs. [REDACTED] around the income to their household from SU1 in terms of carers' allowance, disability allowance with fuel supplement, electricity allowance and telephone rental. The professionals meeting decided that there would be a gradual phased planned move to a residential placement either from Monday to Friday with weekends in the FP's or Monday to Friday with the [REDACTED] and weekends in the residential placement, although it was stated that the five day placement in the

residential placement would be preferable. There was also further discussion around the financial impact for Mrs. [REDACTED] and some discussion around whether Mrs. [REDACTED] could be invited to apply for other positions of care work such as home support worker.

- 4.6.19. Mrs. [REDACTED] was written to in early April 2001 and then attended a meeting with Social Worker H14 as well as H15 on 20<sup>th</sup> April 2001. Mrs. [REDACTED] is recorded as being opposed to either of the phased residential placements, i.e. either weekend or weekday but is recorded as agreeing that she would "*think about them*". The [REDACTED] (H15) is recorded on ID3 files as having attended three meetings in ID3 in February and April 2001 to discuss responses to concerns that the former foster mother had with regard to the possible residential placement for SU1
- 4.6.20. It is recorded that on 9<sup>th</sup> May 2001 the [REDACTED] of ID3 Residential Services forwarded an application form to [REDACTED] H14 in respect of SU1. This application was then the subject of a handwritten note from H14 to H15. This note confirmed that Mrs. [REDACTED] did not wish to apply for a residential place for SU1 and that Mrs. [REDACTED] claimed that she was told that she would be "*afforded the same parental rights as natural parents*". The handwritten note refers to a planned home visit for 30<sup>th</sup> May 2001 but there is no record of this visit taking place.
- 4.6.21. On 28<sup>th</sup> May 2001 Mrs. [REDACTED] wrote to the [REDACTED] of the Disability Service and stated that SU1 would not be going to the service. The letter from Mrs. [REDACTED] states that she will let SU1 go to the residential services "*in about June 2006*" to give time as is stated in the letter "*for us to get our own life back together and (SU1) will help us to do that*". This letter was forwarded by ID3 Services to H14 but it would appear that H14 would have already have left the Disability Services when she received that letter.
- 4.6.22. [REDACTED] H14 left Disability Services at some point in June 2001 and this also coincided with the departure of H15. H14 responded on 26 June 2001 to the letter from the Residential Service by stating that both she and H15 had left the Disability Services team. The letter also stated that "... *There has not been an opportunity to legally clarify the issue but hopefully this will be reviewed by (the new Coordinator.) In the meantime, we cannot proceed with (SU1's) placement within your services in July 2001 as planned. I would ask that SU1's name remain on a waiting list if possible.*" On 28 June a letter

was issued by ID3 to the then [REDACTED] [REDACTED] H23 noting that SUI was not availing of the place and seeking discussion on retaining funding for other placements.

#### 4.7. **Key events from July 2001 – August 2001**

4.7.1. There is no documented evidence of a handover from either H14 or H15 to the incoming [REDACTED] (H17). There are verbal accounts of a handover between the outgoing [REDACTED] (H15) and the incoming [REDACTED]. [REDACTED] H14 was not replaced until July 2002. A list of priority cases in the disability area was tabled with the Inquiry Team by H17, who continued to hold that post up to and including the period of this Inquiry (March – October 2010). The Inquiry Team is aware that in correspondence dated 17.10.2001 from H17, SU1 was listed, together with 41 other service users, who were identified as *"Adults with a Learning Disability for which action is needed immediately"*.

4.7.2. It is the case that H17 corresponded with the [REDACTED] ID3 on the 8<sup>th</sup> August 2001 and made alternative arrangements for another service user to take up the available placement and notes *"we understand that (SU1) is not accepting a place right now"*. This letter was responded to by the [REDACTED] of ID3 Services as follows *"Because of the request for placement for (SU1) was made to us by the Health Board, we had little contact with (Mrs. [REDACTED]) I would like to ensure that (Mrs. [REDACTED]) is fully aware that by not accepting that this place, it will be allocated to somebody else and there may not be a place readily available should (SU1) require residential care at short notice. We need to keep in mind that (SU1's) circumstances may change very quickly and some contingency should be in place if an emergency arises"*. There is no written response to ID3 and H17 has identified her listing of SU1 as a priority in correspondence of 17 October 2011 with H23 and the then [REDACTED] in the relevant Health Board Community Care Area as a follow up to the correspondence to her from ID3.

4.7.3. The letter from ID3 of 8 August was followed up by a reported telephone contact from the [REDACTED] ID3 on 5 September 2001 and a file note suggests that H17 had stated that she would write to the former foster mother, (Mrs [REDACTED]) to advise her that the residential place could not be kept open for SU1. The note further indicates that H17 reportedly stated that she would write to Mrs [REDACTED] advising her of this. There is no record of any such correspondence being issued. There is no

evidence that SU1's file was examined by the incoming [REDACTED] H17, who has indicated that files would not be examined unless there was a "very high priority or a crisis/emergency". However an internal memorandum relating to financial allowances from the [REDACTED] dated 8 November 2001 refers to SU1 being in foster care with the [REDACTED] since 1988 and refers to correspondence in 1996 between the FP's and the Health Board re the payment of fostering allowance.

4.7.4. A file note dated 10 September 2001, handwritten by the [REDACTED] H17 records that a telephone call was made by the birth mother to H17 with the birth mother querying whether SU1 was to move to residential care. It is further noted that H17 advised the birth mother that SU1 was still with the [REDACTED] and it is noted that the birth mother said this was "ok with her". There is no further correspondence, file notes, or references to SU1 from 8<sup>th</sup> November 2001 until 19<sup>th</sup> August 2004. There is no record of a handover meeting on H18 taking up the post of [REDACTED]

#### 4.8. ***Key Events in the period August 2004 – July 2007***

4.8.1. There is no reference to any interactions between the newly appointed [REDACTED] H18 and SU1 or Mrs. [REDACTED] from July 2002 until August 2004. On 19<sup>th</sup> August 2004 the [REDACTED] of ID3 wrote to H18 requesting if a residential placement was required for SU1 in the future or whether her name could be removed from the waiting list. The letter referred to the previous offer of a place at the request of the Health Board and added "... but her foster mother (Mrs [REDACTED]) would not agree to the placement". H18 wrote to Mrs. [REDACTED] asking if she would confirm if she required residential placement for SU1. Mrs. [REDACTED] responded that she did not require residential placement for SU1. It is unclear as to whether there was any examination of SU1's file prior to correspondence being issued to Mrs. [REDACTED] SU1 was removed from the waiting list at some point in late 2004/ early 2005. There is no record of any written response from H18 to the correspondence from ID3 of 19 August 2004.

4.8.2. H18 left the post of [REDACTED] in September/October 2006. A [REDACTED] had been appointed to Disability Services around that time (H30) and H20 replaced H18. There is no documented handover of information re SU1 on file and there is no recollection of such a handover from interviews conducted with relevant staff.



- 4.8.3. There are no references on SU1's file to any interventions or interactions for the period 30 August 2004 – 31 December 2004.
- 4.8.4. There are no references on SU1's file to any interventions or interactions for the period 1 January 2005 – 31 December 2005.
- 4.8.5. There are no references on SU1's file to any interventions or interactions for the period 1 January 2006 – 31 December 2006.
- 4.8.6. There are no references on SU1's file to any interventions or interactions for the period 1 January 2006 – 20 July 2007. On that date SU1's birth mother made a telephone call to LHO1 which was returned by H20. This phone call led to an examination by H20, of the file and the file was brought to the attention of the newly appointed [REDACTED] (PD3).

4.9. ***Key events in the period August 2007 to January 2008***

4.9.1. On 7 August 2007 a discussion is noted on file between H20 and the [REDACTED] PD3 arising from the telephone conversation with the birth mother on 20<sup>th</sup> July and the subsequent examination of the SU1 file. There is an indication on file that at that point there was some initial suggestion by the [REDACTED] (PD3) to the birth mother on accessing information relating to her daughter through Freedom of Information (FOI). Arising from these conversations and the examination of SU1's file, additional files referring to other service users who were resident or availing of respite services in the FP's were examined by the [REDACTED] (PD3).

4.9.2. On 15<sup>th</sup> August, following the file review, PD3 advised H17 of his concerns re placement of SU1 evident from the file examination and advised in a letter of that date that he would make further enquiries. Among the issues of concern identified were:

- The lack of any recorded contact on file from May 2001.
- The lack of recorded actions taken arising from case conferences in 1996 and Professionals Meetings in 2001 relating to the service user.
- Evidence on file of the Health Board receiving allegations of child sexual abuse against the male foster parent (deceased since 2001).

PD3 followed up through direct contact with ID1 Day Services. That contact is indicated in paragraph 4.9.5 below

4.9.3. The Inquiry Team understands that in the course of his examination of the SU1 file, PD3 identified the initials (SU3), another service user who had raised serious concern regarding the [REDACTED] placement in that region. The Inquiry Team understands that on the basis of the initials of service user (SU3), PD3 made contact with one or more individuals by telephone to determine this service user's identity. The Inquiry Team understands that service user SU3 was identified in this manner. On the basis of that telephone conversation PD3 drew up a note which referenced allegations relating to a period when SU3 was on a "boarding out" arrangement with the [REDACTED] while SU3's mother was in hospital in 1999. The Inquiry Team understands that the note of the telephone conversation between PD3 and SUR3 included reference to a HB3 solicitor being present when the allegations were being addressed by the then [REDACTED]

██████████ and that the note taken by PD3 also suggested that SUR3 felt under pressure to withdraw the allegations made. The Inquiry Team further understands that PD3 subsequently clarified that it was SUR3 who was accompanied by her solicitor at the meeting with PD3 and that there was no solicitor present from the HB3.

4.9.4. On 21<sup>st</sup> August H17 emailed PD3 requesting a discussion re SU1, whom PD3 had identified as a vulnerable adult and H17 requested that PD3 conduct a preliminary assessment of SU1's situation as follows:

- *" To carry out a full assessment of (SU1's placement and complete a report on this*
- *If ascertained that current protection issues to advise her as "this should be dealt with in line with the draft policy for the protection of vulnerable adults".*
- *An urgent meeting would be required to make recommendations re a protection plan for (SU1) and options for future placements*
- *Asked that previous personnel are linked with to fill in gaps*
- *If no protection issues identified that a care plan may be put in place with the Disability Team in conjunction with current and potential service users."*

4.9.5. On 22 August 2007 PD3 met ██████████ (SP1) who advised that SU1 was frequently absent from Day Services and PD3 learned of SU1's "chaotic behaviour" when she first attended Day Services.

4.9.6. On 23 August 2007 PD3 and ██████████ (H21) made an announced visit to the ██████████ and made a number of observations in respect of a lack of clarity in relation to sleeping arrangements for SU1 and a lack of clarity in respect of the numbers of individuals who either slept in the ██████████ home or in adjacent outbuildings. The Inquiry Team heard in interview that H21 had concerns re SU1's unkempt appearance.

4.9.7. On 24 August the ██████████ PD3 telephoned SU1's birth mother. This conversation was noted by PD3 and furnished to H17.

4.9.8. On 18 September ██████████ PD3 queried Garda Sergeant (G1) on the status of any investigations into complaints made re service user SU2 in Great Britain allegedly relating to a placement at the FP's. PD3 was also advised on that date that

the [REDACTED] of ID1 Day Services would furnish attendance records for SU1.

- 4.9.9. On 19 September (LA2) solicitors confirm that the HB3 did not make an application for Ward of Court for SU1 in 1996.
- 4.9.10. On 27 September PD3 confirms with Superintendent (G2) that no investigation of the SU2 complaint had taken place in the absence of a formal complaint being made.
- 4.9.11. On 10 October (possible inaugural) meeting of Vulnerable Adults Committee (VAC) chaired by [REDACTED] (H22). Role of investigating complaints assigned to PD3.
- 4.9.12. At some point in October 2007 PD3 requested that PD2, [REDACTED] at ID1 keep a residential place open for an unnamed client.
- 4.9.13. On 14 November at a VAC meeting, [REDACTED] PD3 presents a verbal assessment of SU1 and explained the complexity of the case and outlined previous allegations from families of other service users relating to the placement and is recorded in the minutes as "reviewing the current situation" re SU1 living with Mrs. [REDACTED]. A case conference was proposed but this was resisted by PD3 on the basis that he was unhappy to proceed without legal advice re information sharing with non HSE staff and in reaching decisions with non HSE agencies. PD3 advocated seeking legal advice to proceed with application to make SU1 a Ward of Court.
- 4.9.14. On 26 November [REDACTED] PD3 emailed [REDACTED] (H22) and copied the [REDACTED] H17 in respect of the approaching case conference and stated that the meeting would have to raise issues in respect of allegations against the [REDACTED] both of a "*sexual and financial nature*". The email further stated that the legal framework for addressing the issues was unclear. PD3 particularly raised concerns that there was no equivalent legislation to child protection legislation with regard to making allegations of potential abuse and no law or clear guidelines around information sharing including case conferences. PD3 stated that he understood that statements made in good faith within the HSE may be covered by qualified privilege in terms of defamation but was unsure if this extended to outside agencies. He stated that it had appeared that in the past the legal difficulties have undermined the welfare issues. He proposed that prior to any official meetings in regard to vulnerable adults that include external agencies that they meet with the LHO1 legal advisors to highlight the issues and to

obtain written legal advice, which would allow matters to progress and to prepare for legal difficulties "*as they are encountered*".

- 4.9.15. On 26 November 2007 the [REDACTED] H22 emailed H17 inviting her to case conference on the 12 Dec 2007 and clarifying:

*"The purpose of the conference is to bring together service representations, key individuals and concerned parties where matters relating to SU1 can be explained and plan agreed to respond where possible to meet current and future needs"*

- 4.9.16. On 27 Nov 2007 the [REDACTED] H17 met with the [REDACTED] (PD2) to secure a residential place for SU1.

- 4.9.17. On 7 December 2007 the VAC met and further discussed the issue of holding a case conference. It was agreed that legal advice would be obtained on holding a case conference.

- 4.9.18. On 10 December the LHO1 legal advisors (LA2) wrote to the [REDACTED] H22 re the holding of a case conference and advised that in order to advise HSE re case conference, a full report on this vulnerable adult, purpose of case conference, who would be attending would need to be furnished to them. The advice also stated that a reasonable test should be taken particularly where legislation does not cover certain matters and if allegations are made these still should be taken down in detail and then the carer should be given an opportunity and due process to deal with these allegations and careful notes of all meetings and allegations should be taken. The advice concluded that if there were to be other professionals e.g. G.P., Gardai, any information shared should not be passed on to any third party and all persons present should always act in the best interest of the vulnerable person. It was noted that [REDACTED] had also spoken to the legal advisors and had undertaken to provide a written report "*for the purposes of obtaining legal advice*".

- 4.9.19. On 12 December, the case conference planned for this day was cancelled and the [REDACTED] H17 responded to this by stating in an email to the [REDACTED] (PD3) concern that the HSE was in possession of information re SU1 which required action and that no action was currently being taken. The email also pointed to the [REDACTED] having presented verbal information re service users "*one of whom could be in a position of ongoing risk*" and requested [REDACTED] to prepare a report based on "*...information available to you at this time in that matters may proceed*". The [REDACTED] responded by return on that date stating

*"... (The) correct way to proceed is to have our legal advisors to provide legal advice as to how to proceed. No such meeting has been approved. Please note in 1996, decision to take legal advice not acted upon..."*

4.9.20. On 17 December 2007 the VAC meeting discussed the cancellation of the case conference, and the [REDACTED]s recorded as raising issues around the SU1 case regarding confidentiality and sharing of information. He is also recorded as stating there was a need for legal representation *"... to protect the HSE and the person involved"* It was noted from the [REDACTED] (H17) that National Protocols are being devised in regard to processing concern regarding vulnerable adults. In the interim it was agreed to utilise the draft policies of the relevant HSE region.

4.9.21. At some point in December (LA2) solicitors requested a written report from [REDACTED] PD3 with a view to seeking Counsel's Opinion.

4.10. ***Key Events in the period January 2008 – 31 December 2008***

4.10.1. On 14 January 2008 H17 noted on the file that she had declined to transfer SU1 to the placement in ID1 without first obtaining consent from the birth mother. At this point H17 has stated that she became aware of the existence of the birth mothers consent to transfer to a residential placement dating from late 2000.

4.10.2. The [REDACTED] PD3 prepared a written report and tabled it for consideration by the VAC in January 2008. He emailed members of the VAC the draft with an email stating inter alia that he:

- Opposed the sharing information in the report beyond HSE Managers until legal written advice received on all of the contents therein.
- Indicated that the report contained serious allegation of both criminal actions and institutional failure with huge ethical and confidential issues to discuss prior to proceeding.
- Indicated a need to discuss Ward of Court to protect SU1's interest

4.10.3. The Inquiry Team notes that a VAC meeting took place on 17<sup>th</sup> January where the following points of action were identified:

- That a written report from PD3 would be circulated to the members.
- That in the absence of a National Vulnerable Adult protocol that there was agreement to utilise the draft policies of HSE1.
- That an offer of residential placement for SU1 would be made to Mrs. [REDACTED] and a letter making that offer would be copied to SU1's birth mother
- That PD3 would make arrangements for the referral of SU1 for assessment services such as audiology, psychiatry, and psychological assessment and that Mrs. [REDACTED] would be informed of this.

4.10.4. On 5 February the VAC held a further meeting where it is noted that [REDACTED] PD3 again expressed his view that a legal opinion be sought from the HSE solicitors regarding a possible Wardship process re SU1. It was agreed that the [REDACTED] H17 would:

- Contact Mrs. [REDACTED] re offer of residential placement
- Contact ID1 with regard to referral of SU1

The Inquiry Team notes that H17 in an e-mail to PD3 and the VAC referred to reported discussion between PD3 and PD2 [REDACTED] which suggests that PD3 sought to have a residential place reserved for SU1 for one month only when he discussed this matter with the [REDACTED] (PD2) in October 2007

It was also recorded that a legal view was to be explored following the above two actions in respect of the consent issue and actions to be taken with Mrs. [REDACTED]

4.10.5. On 14 February 2008, H17 emailed PD2 re confirmation of holding a residential placement for SU1. PD2 reverted to H17 and advised that an application for SU1 needed to be forwarded for discussion at the admissions meeting in order that her suitability could be ascertained.

4.10.6. On 15 February 2008, H17 emailed the VAC advising that she would do formal letter of referral to ID1 for SU1. It is noted that PD3 requested of PD2 that a place for SU1 be kept for one month.

4.10.7. The Inquiry Team notes that e-mails from H17 to [REDACTED] [REDACTED] dated 20 February 2008 take issue with [REDACTED] PD3 re alleged failure to follow up decisions of the VAC..." *When a consensus is reached at a meeting and follow up actions are agreed it is important to*

*proceed as planned where a client is at risk. Some of the reasons you raised was lack of consent to refer this client and lack of legal framework. There will be situations where consent may not always be in place and we are obliged to act in the clients best interests. We are all aware of the lack of legal framework in this area and share your concern in relation to this, however the lack of legal framework is no reason for inaction and I repeat we must all act in the clients best interests in line in what is agreed at our meetings."*

4.10.8. On 5 March 2008 the [REDACTED] PD3 wrote to H17 stating "There was no consensus at this meeting (re actions) as I declined to do anything other than to await legal advice". There is no record that this position was articulated at the meeting. PD3 confirmed to H17 that he had completed a lengthy report solely for legal purposes. In a further email to other members of the VAC, PD3 summarised his understanding of the position as follows:

- Main issues at this stage are the client's severe disability and her effective abandonment by her family
- Clear there is a legal framework in terms of Wardship proceedings
- Happy to bring this matter to court to afford SU1 the protection she deserves
- That there was no consensus at the meeting as PD3 declined to do anything other than await legal advice and that this was in the client's best interests as in this case only the law was able to protect her and that acting without the mother's permission or the legal framework could be construed as "taking the law into our own hands".

4.10.9. On 6 March 2008 a VAC meeting was held, the focus of which was to review and provide an update in relation to SU1's case. Possible actions discussed included:

- Approval to meet LHO1 solicitors.
- Recorded that an external clinical psychologist had been requested to carry out assessment of SU1

The Inquiry Team notes that it is recorded that the VAC meeting discussed the implications of a Wardship application on behalf of SU1. It is further noted that the following remark was recorded as being stated at that meeting... "It was stated the Judge at a court sitting may consent in relation to wardship, however, the independent person who may be appointed may explore aspects of the case from a historical perspective which the HSE may find difficult to answer".



- 4.10.10. On 7 March 2008 the report by [REDACTED] PD3 was forwarded to LHO1 solicitors.
- 4.10.11. On 14 March the H17 and the chair of the VAC, Child Care Manager (H22) met with the LHO1 solicitor (LA2).
- 4.10.12. On 20 March 2008 an email from H17 to the [REDACTED] (H31) stated that a number of issues had arisen following a meeting with LHO1 solicitors. It was agreed that it was best if H17 followed up on this case rather than PD3, "given the delicacy of the situation". File note from March 2008 states that the [REDACTED] (H22) in discussing a potential Ward of Court application repeated the concerns re the difficulties presented for the HSE as quoted in 1.10.9 above.
- 4.10.13. On 25 March 2008 in an email from H17 to the [REDACTED] (H23) and [REDACTED] (H31) stated "I have briefly discussed this case with you. (H22) and I have met with (LHO1 solicitor) and there are a number of actions which need to be taken. However, I am not anxious to proceed without a more detailed discussion with either or both of you because there are very serious consequences to any actions we take".

- 4.10.14. A letter was received from LHO1 solicitors on 26 March 2008 advising that SU1's birth mother was to be contacted and consent sought for various services to be put in place for SU1 by the HSE. The letter also stated SU1's birth mother was not entitled to information not pertaining to her own daughter. The letter further stated that Mrs. [REDACTED] should be contacted and encouraged to have SU1 brought to various services and only if she refused to do this should the consent from the mother be used to ensure that these matters are to be attended to in the best interest of SU1.
- 4.10.15. On 31 March 2008, H17 advised the PD3 that he was to cease further investigation and the files were removed from PD3's office. H17 has advised that due to her concerns across a range of issues she felt that....."*...the only recourse open to her was to remove the files from PD3 pending discussion with the [REDACTED] to see advice with regard to how to proceed, and to ensure and to ensure that appropriate supervision would be offered to PD3*". She added that *..." Once this was in place, H17 was very happy to return the file."* These files were subsequently returned in May 2008.
- 4.10.16. On 1 April 2008 a hand written note from H17 stated that it was not possible to write to Mrs. [REDACTED] with the offer of residential placement as H17 had contacted ID1 who indicated that in the absence of a formal referral, no place had been held for SU1.
- 4.10.17. On 6 April 2008 the PD3 was asked by H17 "Please do not take any action in relation to this case until further instruction."
- 4.10.18. On 23 April 2008, H17 spoke to SU1's birth mother by telephone re obtaining consent. SUR1 allegedly raised concerns as to how PD3 had communicated with her in August 2007. These concerns were subsequently set out in an email from H17 to both PD3 and the newly appointed [REDACTED] [REDACTED] H25 (appointed 28 April and became operational on 14 May 2008).
- 4.10.19. On 24 April 2008, H17 wrote to SUR1 confirming that SUR1 had agreed to a residential placement for SU1. That letter included a letter of consent for medical assessments to be signed by SUR1. Signed consent form was subsequently received on 30<sup>th</sup> April.
- 4.10.20. On 28 May 2008 a meeting took place between H17 and the incoming [REDACTED] (H25). It was agreed that H25 would supervise PD3 on a monthly basis and that PD3

would supervise H21. There had been an acting [REDACTED] in place for a period of 14 months but there was no recorded involvement by that individual (H30) in any issues around the management of the SU1 case or the supervision of the [REDACTED] (PD3). The meeting also notes agreement that PD3 would be asked to resume responsibility for moving the SU1 issue forward.

4.10.21. A VAC meeting was held on 29 May 2008. Notes of that VAC meeting suggest that the following was discussed, including:

- That consent had been received from SUR1 for multidisciplinary assessment and residential services
- That it was noted that a participant at the meeting expressed reservations that SUR1 had not been informed of HSE concerns.
- A report from H17 that legal advice had indicated that consent be sought from the birth mother.

The recorded actions to be undertaken from that VAC meeting were noted as follows...

- Ask ID1 to have admissions meeting
- Share information directly about SU1 with ID1 and suggest that she needs check ups as she has missed day service.
- Carry out the multidisciplinary assessments after she moves
- Inform (Mrs. [REDACTED]) very close to the admission date.

Separate discussions took place on that date between H17 and PD3. The file note indicates that there was some discussion around the membership of the VAC with PD3 indicating non HSE personnel (Gardai, Local Authority) should be on the VAC, with H17 indicating that there should be formal links with agencies such as the Gardai and the VAC. It is further noted that the SWTL was informed of the alleged comments made by SUR1 in respect of telephone conversations dating from August 2007.

4.10.22. On 18 June 2008 the [REDACTED] (PD3) wrote to SUR1 inviting her to discuss SU1's care and advising that Mrs. [REDACTED] would strongly oppose any attempts by the HSE to remove SU1 from the placement. [REDACTED] also suggested that SUR1 make an FOI application to obtain files regarding her daughter from the HSE and enclosed relevant documentation for her to sign in following such an application. There is no indication that this approach was discussed in advance with the VAC or with H17 or with PD3's line manager, the Principal Social Worker.

4.10.23. On 23 June, the [REDACTED] PD3 forwarded a detailed email to H17, copied to other members of the VAC and to the Principal Social Worker. These concerns included:

- [REDACTED] concern that legal advice obtained was not based on the report that the [REDACTED] had submitted
- That the legal advice obtained did not refer to application for Ward of Court and did not address SU1 moving out of the [REDACTED] and that it was unclear how SU1 could be moved legally from Mrs. [REDACTED]
- [REDACTED] view that the Courts would say that allegations of sexual abuse in the foster placement would directly effect SU1 and she was therefore at risk of sexual abuse.
- [REDACTED] view that the birth mother was entitled to know that there had been allegations in respect of the placement and this was one of the reasons this was being terminated.
- That if the law was unclear on this matter, that Senior Counsels advice should be sought.
- That the [REDACTED] could not understand the reluctance to go to Court except that the Health Board/HSE are afraid it would be critical of their record of protecting SU1.
- That the [REDACTED] and H21 would be visiting the [REDACTED] that day (prior to the VAC meeting scheduled for the next day).

4.10.24. The VAC meeting of 24 June noted that the [REDACTED] PD3 and H21 had visited the [REDACTED] the previous day and advised Mrs. [REDACTED] that the SU1 placement had no legal basis and that an alternative placement was being made available to SU1.

The Inquiry Team notes that there is no reference in the VAC minutes of [REDACTED] advising the VAC that he had strongly urged and offered assistance to SUR1 to lodge an FOI request for all files on SU1 held in the offices of LHO1 Disabilities Team.

The Inquiry Team understands that the [REDACTED] had suggested that urging/facilitating an FOI request in this manner would not be unusual among child protection social workers. The minutes also indicate that ID1 Day Services had been contacted and that

SU1 was attending Day Services more regularly, and that her weight, which was quite low, was being monitored. It is minuted that H17 would consult with the [REDACTED] regarding the next steps and that the [REDACTED] (PD3) would liaise with ID1 Day Services. The Inquiry Team notes that the record of the VAC meeting was disputed as between [REDACTED] and H17.

4.10.25. On 1 July the [REDACTED] PD3 emailed the [REDACTED] [REDACTED] H17 detailing injuries to SU1 identified from ID1 Day Services records. The [REDACTED] suggested one of those injuries was consistent with "possible friction burns". The following exchanges also occurred on this date:

- email from H17 to [REDACTED] asking him not to write to SU1's birth mother regarding Mrs. [REDACTED] resistance to residential placement.
- It is noted that at the end of the email [REDACTED] has already sent letter and H17 requested copy.
- Note from H17 [REDACTED] and cc'd. to VAC confirming to [REDACTED] that she has discussed this case with the [REDACTED] H23 and the advice was to continue with the decisions made at the VAC.
- email from [REDACTED] to H17 and cc'd [REDACTED] (H26) querying how the advice from the [REDACTED] decision to proceed with the decisions of the VAC was consistent with the decision of the VAC to seek advice from him.
- [REDACTED] acknowledged that he did visit the [REDACTED] with the H21 to ascertain Mrs. [REDACTED] current position on SU1 moving, which she stated remained unchanged from her previous position.
- [REDACTED] recommend that SU1 be made a Ward of Court and that he saw no other intervention possible to him as [REDACTED] for vulnerable adults.
- [REDACTED] stated that information from ID1 Day Services was that SU1 had scratches on her back and also red marks on her spine and possibly friction burns but there had been no identified cause. (The Inquiry Team has established that the only reference to friction burns was from [REDACTED] and it did not appear in any incident report or other report provided by ID1 Day Services personnel. The [REDACTED] acknowledged to the Inquiry Team that there was no such reference in any documentation other than in his email of 1 July 2008)

4.10.26. On 3 July email from H17 to the [REDACTED] (H23) advising of the offer from ID1 Day Services for a trial placement for SU1 during which she would have appropriate assessments. It was queried whether the offer of placement should be made to the mother/ client / carer or all three and whether this would be done in conjunction with a joint visit by the HSE and ID1. The [REDACTED] was also advised that SUR1 had been written to and had given consent based on a specific amount of information given to her.

Also on that day a meeting as held at ID1 re admission of SU1 for a trial placement and who to make the offer of placement to and it was agreed that if there was opposition the matter would be dealt with by the HSE and ID1 agreed to keep this vacancy open while this matter was progressed by the HSE. There is no reference in the minutes of the meeting re concerns about the placement.

4.10.27. On 7 July the [REDACTED] advised H17 to proceed to offer the placement and legal avenues were discussed with the solicitor in the event of resistance to the move from Mrs. [REDACTED] H17 or a nominee was to advise the birth mother and [REDACTED] of the placement.

Also on this date H17 emailed the [REDACTED] (H26), [REDACTED] (H22) and the [REDACTED] (H25) that based on advice from the [REDACTED] H17 would seek a meeting with [REDACTED] and she would be given a letter re the proposed placement. In the event of resistance to the transfer, H17 would outline some of the concerns re non attendance at Day Services and unexplained bruising etc. The offer of placement would also be communicated to the birth mother, SUR1.

4.10.28. On 9 July 2008 an email plus attachment was forwarded from the Chair of the VAC (H27) to H17 outlining concerns re [REDACTED] actions around the SU1 case. Those concerns included notifying Mrs. [REDACTED] of the possibility of a move for SU1, contrary to the decision of the VAC meeting on 29 May, which decided to wait until a date nearer the transfer to advise Mrs. [REDACTED] H27 expressed the opinion that the home visit by the [REDACTED] in June 2008 had the effect of putting SU1 "more at risk". In addition H25 expressed concerns around the letter from [REDACTED] to the birth mother advising her to request information under FOI given that the decision of VAC was to discuss such detail with SUR1 after assessment in new care environment. H25 also expressed concerns around the possibility of applying for Ward of Court and speculated that the Court would ask what actions had been taken by the HSE or other relevant body to ensure

the person's safety and interest. The letter concluded that this was the legal advice given re this case and was why the VAC wished to proceed as stated above; however the management of this case needed to be reviewed immediately in order for the best interest and the protection of this client to be secured.

4.10.29. On 10 July H17 emailed members of the VAC that actions as agreed at the VAC had been followed including an admission meeting arranged with ID1 and a plan to meet with Mrs. [REDACTED] along with a representative from ID1.

4.10.30. The Inquiry Team notes that the VAC at its meeting dated 15 July further clarified that the [REDACTED] would act as Designated Person who would receive referral of suspected abuse of persons with a disability.

The Inquiry Team notes that the meeting also accepted that the following actions would be followed up:

- H17 reported on actions followed up as agreed
- Discussion held with [REDACTED]
- Followed agreed actions of VAC as advised
- ID1 to offer residential placement
- Trial placement offered subject to outcome of assessments
- Offer of placement to Mrs. [REDACTED] and birth mum as advised by [REDACTED] and [REDACTED] (H25)
- H17 and rep from ID1 to meet with Mrs. [REDACTED] re this offer
- [REDACTED] to ask Mrs. [REDACTED] her age

There is no record of any disclosure of SU1 concerns being made to ID1.

4.10.31. On 21 July the [REDACTED] (PD2) and H17 met with Mrs. [REDACTED] to offer the placement, which was refused. Mrs. [REDACTED] was reminded that the offer was originally made seven years ago and had been deferred five years at Mrs. F [REDACTED] request. Mrs. [REDACTED] indicated that she would be seeking advice on the matter. H17 outlined to Mrs. [REDACTED] that legal advice would be sought by the HSE in the event that SU1's guardian or parent were not acting in the best interest of SU1 and options such as Ward of Court would be considered. Mrs. [REDACTED] was also queried about taking SU1 to the General Practitioner and asked if SU1 ever attended a GP when she was absent from Day Services due to ill health, to which Mrs. [REDACTED] is reported as answering in the negative.

4.10.32. On 20 August SU1 attended ID1 Day Services where it was noted that she had bruising and broken skin around the eye area in addition to an older injury to the finger of one hand. The [REDACTED] (PD1), referred this issue to the [REDACTED] (PD3) and SU1 was taken to A&E, Hospital 1. The [REDACTED]

██████████ from ID1 (PD1) and the ██████████ PD3 accompanied SU1 to the ██████████ following the visit to A&E.

4.10.33. On 21 August H17 emailed the ██████████ (H23) and the ██████████ (H25) and outlined the meeting with Mrs. ██████████ and confirming Mrs. ██████████ refusal to accept the placement. The report on the unexplained bruising and SU1's visit to Hospital 1 was raised. It was reported that Mrs. ██████████ had taken SU1 to the General Practitioner but there was nothing to report. Actions to be taken were:

- Write to carer to reconsider her position
- Inform birth mother of carer's position
- Seek what legal options were available.

Also on this date H17 wrote to ██████████ (H23) and ██████████ (H26) informing them of SUR1's request for files pertaining to her daughter as had been suggested by the ██████████. The ██████████ (H23) replied to H17 advising that he may be involved in an appeal if all files are not released and it would be better for the ██████████ to deal with this, but this would not preclude H23 with regard to overall discussion re the case.

4.10.34. On 22 August 2008 the ██████████ H23 emailed H17 and the ██████████ (H26) advising that professional opinion was to move SU1 to a residential setting and if the offer was not accepted that they would need to find a way to effect the move. Legal approaches to be considered due to the carer's resistance. Need strong case based on evidence. [\*\* construct full sentence here] Query full time placement or part time placement. It was stated that care had to be taken due to renewed interest of the birth mother.

4.10.35. On 26 August 2008 the VAC met and minutes noted the following:

- Meeting was held with Mrs. ██████████ to offer placement. Mrs. ██████████ not happy with this and will take legal advice
- Mrs. ██████████ declined the offer in writing to ID1.
- ██████████ wrote to SUR1 advising to request files under FOI and SUR1 had done this
- ██████████ H17 met with the ██████████ (H25) and agreed on actions.
- Bruising noted by day service and SU1 accompanied to Hospital 1 where bruising and slight abrasions confirmed.



- Mrs. [REDACTED] aware of bruising but took no action.
- Mrs. [REDACTED] took SU1 to General Practitioner. No outcome.
- [REDACTED] felt that SU1 presented unkempt, teeth and hair poor.
- It was agreed to ask [REDACTED] (H5) for her opinion on SU1's physical position and any background information.
- H17 to arrange dental appointment for SU1 and query with Mrs. [REDACTED] H17 will ask ID2 psychological assessment.
- Key person is H17 and she was to seek legal advice, update birth mother and write to Mrs. [REDACTED] to reconsider.
- Key person is [REDACTED] to speak with General Practitioner re update and opinion of SU1's health and to contact the [REDACTED] (H5) re SU1's physical condition.

4.10.36. On 29 August H17 emailed the [REDACTED] (PD2) requesting the place remain open to SU1 as the case was at a critical stage.

4.10.37. On 1 September H17 emailed the [REDACTED] (H26) re seeking legal advice and seeking discussion. H17 also sought copies of the written report from Hospital 1 from the [REDACTED] (PD3). She summarised the SU1 case as follows:

- Write to carer re change of position
- LA2 solicitors had been contacted for advice and they were concerned that the HSE keep in contact with birth mum, keep monitoring client, have regular contact with SU1's GP, and offer as many assessments as possible. The email goes on to say "*He (the solicitor) suggests that legally we have very few options. If we seek to take the client back into the care of the HSE a judge would need strong evidence of why it is necessary given that she has been in this woman's care for so long. The Judge would need to see that it is in the client's best interest and there is little evidence of this. The court will likely ask what have the HSE been doing for the past years for this client.*"
- H17 further stated "*The natural mother continues to have rights despite her lack of contact, however it is vital we are on side, unfortunately the FOI request may hamper this. If the biological mother seeks to have the client removed from the carer she would also need to have good reason.*"
- H17 also stated that the HSE were left with very few options and asked the solicitor would it be helpful if the HSE could sent a letter from the solicitor to the Mrs. [REDACTED] suggesting that the HSE would apply for ward of court if she continued to resist the offer of residential

placement. Legal advice was to seek legal counsel on the case which H17 asked him to proceed with.

- H17 informed the [REDACTED] H26 that she had asked to retain SU1's place.
- It was agreed at VAC to seek assessments for SU1 and offer to Mrs. [REDACTED]
- PD3 was to follow up with [REDACTED] and GP re SU1's physical background and condition. Relevant due to the fact that client had bruising, and went to Hospital 1 which concluded that SU1 had some bruising and some minor abrasions of unknown cause.

4.10.38. Also on 1 September 2008 H17 emailed the [REDACTED] copied to the VAC, asking him to send her a copy of any information to the GP or [REDACTED] prior to it being sent out and suggesting in future the [REDACTED] see SU1 and report on SU1's condition when she makes a home visit. H17 also asked for a written report from Hospital 1. H17 also asked PD3 to make a formal written request to [REDACTED] (PD1) at ID1 to monitor SU1 following the incident and report back on a weekly basis re SU1's physical condition.

4.10.39. On 2 September the following correspondence is documented as follows:

- (9:31) email from [REDACTED] to [REDACTED] (H25) and cc's to H17 asking for immediate supervision on this case, stating that he can no longer work on this case under the current circumstances
- (10.48) – email from H17 the Chair of the VAC (H27) looking for advice re if appropriate to ask [REDACTED] to follow up as some of it was agreed at the VAC.
- (10.53) – email from H17 to [REDACTED] (H25) requesting to discuss SU1's case asap "*...most of what I asked [REDACTED] to do in my email was agreed actions at the recent VAC, some additional requests about how things should be done were on advice from (H25) and our legal advisor*"
- (10.55) – email from H17 to [REDACTED] (H26) asking advice re discussing case with H25's deputy in his absence
- (16.33) email from [REDACTED] (H26) to H17 who asked "*what reason did he [REDACTED] give for not working on this case going forward*"
- (16.56) – email from H17 to [REDACTED] (H26) "*I have only received the enclosed copy of mail to (H25) so I have not heard any reason*"

- 4.10.40. On 3 September H17 spoke to the birth mother SUR1 by telephone and advised her that her daughter had sustained some bruising but that it was not clear how this occurred. On that same date H17 wrote to the [REDACTED] asking if he was going to follow through the decisions taken by the VAC and actions, as requested by [REDACTED] (H25) and legal advisor. It is noted that on that date files have been requested re SU1 by way of an FOI application.
- 4.10.41. On 4 September the Chair of the VAC (H27) emailed H17 advising that it was appropriate to ask PD3 to follow up on actions agreed at VAC " *maybe to prevent future misunderstanding or disagreement we should continue to outline exactly at each VAC meeting the actions that (PD3) and indeed each member have agreed to carry out*".
- 4.10.42. On 8 September 2008 LA1 solicitors wrote in error to the former [REDACTED] (H14) (1999 – 2001) re seeking opinion of senior counsel as to " what avenues are open to the HSE to insure that (SU1) is being adequately cared for" and advising that paper sent to Barrister at Law (LA3). This letter was copied to the [REDACTED] (H26).
- 4.10.43. On 10 September H17 wrote to Mrs. [REDACTED] asking her to reconsider her position on SU1's residential placement given her commitment to SU1's best interest and advising re assessments that are planned and asking her if she could take SU1 to the assessments and if not that Day Care would do so. The letter also asked Mrs. [REDACTED] to let her know what would be convenient for her.
- 4.10.44. On 16 September Mrs. [REDACTED] wrote to H17 stating that she wished to keep SU1 for another two years.
- 4.10.45. On 17 September a Solicitor LA1 wrote to the [REDACTED] (H26) re SU1 stating that H17 was in contact a few weeks ago and confirmed that counsel's opinion should be sought on what steps the HSE could or should take to protect this adult " *as she may not be capable of managing her own affairs. As you know we discussed the matter in detail ... and it was felt that this is a case not without it's difficulties for the HSE for a number of reasons and has to be handled in a very sensitive manner. I have initial verbal advices from counsel regarding a possible ward of court application and I am awaiting the formal written advice regarding same.*"
- 4.10.46. On 26 September 2008 Legal Opinion issued by Barrister at Law (LA3) to the [REDACTED] proposing that an application for Ward of Court be processed " *as a matter of*

urgency". There is no evidence that this Legal Opinion was furnished to the [REDACTED] or that a copy was provided to H17 and no evidence that opinion was sought by the [REDACTED]

4.10.47. The Inquiry Team notes that a minute of the VAC meeting of 29<sup>th</sup> September 2008 provided the following update re SU1...

- It was claimed that SU1's GP had not seen her for six years
  - A final request was to be put to the [REDACTED] in SU1's geographical area to carry out a physical assessment
  - H17 alleged that the [REDACTED] (PD3) was not following up on actions agreed at VAC and this was disputed by the [REDACTED]
- A file note from the [REDACTED] (PD3) suggests that the [REDACTED] (H5) had been misled into not calling to see SU1 in the [REDACTED] as it was suggested to the [REDACTED] that SU1 was attending ID1 Day Services five days a week (attendance records for SU1 indicate sporadic attendance and prolonged absences).

4.10.48. From the period July until mid October the files indicate significant levels of correspondence around alleged failure by PD3 to take action on the basis of decisions taken by the VAC. These alleged failures are contested by PD3. Concerns were also expressed by PD3 that H17, in making regular contact with both Mrs. [REDACTED] and SUR1, was "supplanting the social work role" and [REDACTED] concern that "this case is being worked in two different ways by the same office, which cannot be an acceptable standard of working for the client". H17 has stated that she only took action when it was agreed by the VAC and where she formed the view that agreed actions had not been carried out by PD3 and had consulted with her line manager and legal advisors prior to taking such actions. She also advised the Inquiry Team that she only took such actions when she....." *...feared that further delay would result in increased risk or obstruction/hold up in a positive outcome for the client*"

4.10.49. On 1 October, a request was made for psychological assessment from external provider (ID2) to be carried out on SU1. The reason for the assessment is stated to be in relation to Ward of Court application and possible legal challenge.

4.10.50. On 2 October legal opinion from Barrister at Law was furnished to the [REDACTED] This legal opinion is stated to be based on the report provided by the [REDACTED] PD3 to the solicitors in early 2008. The opinion which reiterates the historical analysis of key events around SU1's care and PD3's

analysis re protection issues in respect of other service users outlines the following steps be taken:

- *"in my opinion it is vital to keep in mind that the paramount important consideration is the health and safety of (SU1). With this in mind I am advising the HSE to proceed with the quickest route possible to get this matter brought to the attention of a High Court Judge – preferably the President of the High Court.*
- *I am of the opinion that the HSE should seek to have the High Court exercise its inherent jurisdiction to protect someone in (SU1's) position. I am, therefore, proposing that a letter be sent to the Registrar or Wards of Court in the High Court and I have drafted the appropriate letter which should be sent by agent. This should be done as a matter of urgency.*
- *The Registrar is likely to have the matter listed before the President of the High Court and he is likely to have notice service on (SUR1) (as the natural mother) and (Mrs. [REDACTED]) (as foster parent)."*

4.10.51. On 7 October email from the [REDACTED] to H17 re Vulnerable Adults Policy, thanked her for copy of [REDACTED] report which he had not previously received. [REDACTED] stated that he had received legal opinion which he advised H17 of that morning but had concerns that he needed to try and get aired and get some decision on in the immediate future and he would keep H17 and VAC informed.

4.10.52. Throughout October 2008 there were a series of emails exchanged between H17 and the [REDACTED] re the psychological assessment and the advisability of Mrs. [REDACTED] having any role detailing SU1's history as part of that assessment. On 28 October a psychological assessment was carried out on SU1, the purpose of which was stated to be a comprehensive assessment of social, emotional and intellectual function. A report from the Psychologist was provided on 31 October 2008 and found SU1 to be in the profound intellectual disability range. The Psychologist noted *"The current care taking arrangement with (Mrs. [REDACTED] – double check) is now becoming of a more time limited nature given the woman's advancing years"*, The Psychologist further recommended the use of respite care as a transition to a residential placement for SU1 and indicated that it was not envisaged that this would be a difficult transition for SU1. The recommendation for SU1 to move to a group home was also stated to be on the basis that

SU1's "social and emotional needs would be more appropriately met in the context of relationship with peers".

4.10.53. On 5 November 2008 a meeting took place to discuss what action should be taken with regard to SU1. The full VAC attended along with the [REDACTED] and the [REDACTED]. There were no external agencies represented at this meeting. A file note drafted by the [REDACTED] provided his detailed recollections of the matters discussed at the meeting. The principal issues discussed related to the potential Ward of Court route and whether solicitors should be instructed to make application for Ward of Court. The [REDACTED] recorded the view of H17 and the Chair of the VAC as seeking to give Mrs. [REDACTED] one further opportunity to comply voluntarily. The [REDACTED] and the [REDACTED] are recorded as favouring instructing solicitors to make application for Ward of Court. It is further noted that [REDACTED] was shown Mrs. [REDACTED]'s letter of 16 September requesting SU1 remain with her for a further two years. There is no evidence that the written legal opinion was furnished to participants at that meeting.

4.10.54. The outcome of the 5 November 2008 meeting as recorded by the PD3 is that a decision was taken to proceed with the Ward of Court application. The steps to be taken to action this included discussing such an application with the birth mother. There was disagreement around who should contact the birth mother given disputed allegations around previous contacts from PD3 with the birth mother. On the other hand PD3 accused H17 of undermining his relationship with SUR1. The outcome of this discussion was that the [REDACTED] (H25) would contact SUR1 and look at the issues allegedly raised by her. It was further agreed that SUR1 would be invited to a meeting and be offered the opportunity to meet SU1 in ID1 Day Services.

4.10.55. It is noted on file that in early December the [REDACTED] spoke to SUR1 and he reported that SUR1 confirmed her concerns regarding her telephone conversation with the [REDACTED] in August 2007 and that those concerns were as communicated to H17 in March 2008.

#### 4.11. **Key Events in the period January 2009 – January 2010**

4.11.1. On 21 January 2009 an email was issued from the [REDACTED] to the [REDACTED] H17 and the [REDACTED] advising that he had spoken with SUR1 on December 3<sup>rd</sup> and informed her that there had been a

meeting of professionals on 5 November and that legal advice had been received re applying for Ward of Court if Mrs. [REDACTED] did not agree to SU1's transfer to residential care. SUR1 is reported as stating that she had no problem with the HSE proposal. It is also noted that SUR1 declined to accept the invitation to meet with the professionals involved or to visit ID1 Day Services and meet with SU1.

4.11.2. On 21<sup>st</sup> January there was a significant volume of emails between H17/ [REDACTED] around meeting Mrs. [REDACTED] and putting the options to her of either agreeing to transfer or being notified that the HSE would initiate a Ward of Court application.

4.11.3. On 23<sup>rd</sup> January it was agreed that H17 and [REDACTED] would meet Mrs. [REDACTED]. The [REDACTED] had noted that a recent application for Ward of Court had failed and he advised that they consider discussing access with Mrs. [REDACTED]. H17 agreed that access would likely be an important issue for Mrs. [REDACTED] and also stated her wish that this matter would not involve Court proceedings. The [REDACTED] suggested in an email avoiding an adversarial position with Mrs. [REDACTED] if at all possible and to emphasise the reasons supporting SU1's transfer. Appropriate access was to be offered to Mrs. [REDACTED] and her grandson. This approach is agreed by the professionals following significant email exchanges.

4.11.4. On 18<sup>th</sup> February H17 and PD3 met Mrs. [REDACTED]. A file note of meeting indicated the following was indicated to Mrs. [REDACTED]

- That a number of assessments had been carried out and it is in the best interests of SU1 to take up residential placement.
- That SUR1 would like placement to proceed.
- That Mrs. [REDACTED] had been met on a number of occasions to take it slowly and now they needed to follow the advice of assessments and professional advice.
- Ward of Court route was advised.

Mrs. [REDACTED] couldn't give a date for the transfer and it is noted that she stated she would "rather die" and that she will have no one when SU1 leaves.

4.11.5. On 19/20 February 2009, there is correspondence from PD3 to H17, [REDACTED] the [REDACTED] Chair of the VAC and H20 stating his position that there was no possibility that Mrs. [REDACTED] would comply and suggested seeking

Counsels opinion before removing SU1 from the [REDACTED] without a Ward of Court application or proceed on the Ward of Court route. Following this correspondence there is an email exchange on the appropriateness of a Ward of Court application in the event Mrs. [REDACTED] did not agree to SU1's removal and concerns that a case would have to be very strong. The [REDACTED] outlined how he had spoken to solicitors LA1 and had agreed tentatively that the Ward of Court route would be the best route in the event of Mrs. [REDACTED] not agreeing to a placement. The [REDACTED] also suggested having a brief meeting to update on the details of the case and the approach to date and have legal opinion preferably prior to that date. The [REDACTED] offered to obtain legal advice.

4.11.6. On 23<sup>rd</sup> February the Chair of VAC agreed that legal advice be obtained as soon as possible regarding a possible application for Ward of Court and indicates that she has been involved in a number of cases where such an application has been very lengthy and the outcome has been a denial of the application.

4.11.7. On 5<sup>th</sup> March the [REDACTED] emailed the LA1 solicitors stating that he was aware that the [REDACTED] would be in contact with him next week, and that the [REDACTED] was concerned to know the position of the HSE if SU1 was simply not returned to Mrs. [REDACTED]. He advised that SU1 appeared to be neglected at times – that she attended to Day Services with unexplained injuries and he asked *"as these concerns mount for (SU1) I would like to know the HSE's legal exposure as to whether we could be construed as neglecting (SU1) by continuing to sanction her return to Mrs. [REDACTED] even pending the attempt to protect her in the courts"*. On the same date, the [REDACTED] in an email to all relevant staff, confirmed that he had raised this with LA1 solicitors the previous Friday and would be discussing further during the week and reverting to all staff involved in the case with the views and advice received.

4.11.8. On 25<sup>th</sup> March the [REDACTED] emailed H17, the [REDACTED] the Chair of the VAC, the [REDACTED] and H20 stating that he would be unable to attend the VAC meeting scheduled for that day and that he believed that it was necessary to 1) prepare for the Ward of Court 2) re access – considered in the best interests of SU1 and supervised if it were to happen and 3) recommend a move asap.

4.11.9. The VAC meeting proceeded on 25<sup>th</sup> March and it was noted that legal advice was being awaited for SU1. It is also minuted that the [REDACTED] (PD3) had agreed to review the draft



Vulnerable Adults Policy and to make recommended changes and additions for circulations to the [REDACTED] It was noted that the Draft Vulnerable Adults Policy was signed off in December 08.

4.11.10. On 27<sup>th</sup> March the following sequence of events unfolded following the discovery of suspicious bruising by ID1 Day Services staff on SU1:

- At 10.00a.m, while SU1 was being showered by Day Services staff, the staff brought what they considered to be suspicious bruising observed on SU1's thigh and breast to the attention of the Manager.. [REDACTED] was contacted and he visited ID1 Day Services
- At 12 mid-day the [REDACTED] is reported to have advised that SU1 be seen by A&E
- At 1.00 p.m. telephone contact was made with the Manager A&E who advised that on the basis of the reported bruising that the Gardai be contacted as a referral to the Sexual Assault Treatment Unit (SATU1) may be appropriate.
- Gardai were contacted on a number of occasions by the [REDACTED] and arrived at ID1 Day Services at 3.50 p.m.
- Following consultation among G, they advised that SU1 be taken to A&E and that following initial assessment there, a decision would be taken as to whether to refer to SATU1.
- Following an examination of SU1, marks deemed to be "suspicious" possibly non –accidental. A Statement was taken by Gardai from the [REDACTED] and SU1 moved to SATU1 at 9.30pm
- The Inquiry Team understands that discussion had taken place earlier that evening by telephone between the [REDACTED] (PD1) and H17, re availability of respite or temporary residential placement that night for SU1.
- The Inquiry Team has been advised by ID1 staff that their recollection is that they informed the [REDACTED] of respite options for SU1 within ID1. The Inquiry Team understands from its interviews with the [REDACTED] that he was unaware of such options and understood that the only available option appeared to be either returning SU1 to her placement or arranging a social admission to a hospital bed in Hospital 1. The Inquiry Team understands that [REDACTED] states that he sought to contact H17 and [REDACTED] out of hours for advice on this matter but was unable to do so.
- The Inquiry team understands that it was [REDACTED] position that he had no legal right to remove SU1 from the placement.
- The Inquiry Team understands that the outcome of the assessment was that no specific evidence of sexual abuse was found at the time

- At 11.25 p.m., SU1 was taken from the hospital and returned to her placement accompanied by PD1, PD3 and the [REDACTED]
- The Inquiry Team understands that with regard to the decision to return SU1 to the [REDACTED], [REDACTED] was of the view that, on balance, this was "the least worst option" and that [REDACTED] was of the understanding that there was no alternative available as it was 11pm with only a hospital bed available in the acute hospital where the SATU1 was located (Hospital 1) and that this bed would not have been an appropriate place for SU1.

4.11.11. Also on 27<sup>th</sup> March, PD3 outlined his observations of the potential legal status of all parties involved in decision making around SU1. In or around that period [REDACTED] also noted for the file that while he was waiting in the ID1 Day Services to discuss SU1's injuries with staff. *"...I went through (SU1's) case notes. These were not available to me when I did my report. These notes contain numerous references to unexplained absences and injuries..."* PD3 requested a full report from [REDACTED] (PD1). There is no indication on file that this information had been requested from ID1 by PD3 prior to this. The Inquiry Team notes that there is little evidence in the files examined of these concerns being raised by ID1 with LHO1 prior to 2008.

4.11.12. From 1-3 April there were a series of emails as follows:

- An email from the [REDACTED] advocating a move for SU1 and a parallel process re Ward of Court application
- A memo from H17 to the VAC team querying alternatives to going down Ward of Court route around parental capacity to consent.
- An email from the [REDACTED] to solicitors (LA1) and copied to the VAC members outlining that following on from recent telephone call he had met with staff and agreement had been reached to:
  - 1) Update the existing report and submit to LA1's office
  - 2) Arrange to meet with LA1 solicitors to finalise arrangements for Senior Counsel to advise on the HSE approach

4.11.13. On 6 April it is noted that [REDACTED] had met with the Gardai to follow up on SU1's referral to SATU1.

4.11.14. On 22 April [REDACTED] provided the [REDACTED] with an update to the original report provided to the LHO solicitors (LA1) in March 2008, with an accompanying letter highlighting a number of significant changes and developments. These developments can be summarised as follows:

i. Parental Permissions

[REDACTED] reported that SU1's mother had been contacted by various staff members and had provided written consent for SU1 to move to the new placement in ID1 Residential Services. He further noted that SUR1 had consented to her daughter receiving medical and other assessments and that SUR1 had been informed that her daughter is a vulnerable adult but had not been informed that there were specific concerns about the placement. The letter also indicated that SUR1 had requested files re her daughter under FOI but had not proceeded further.

ii. The [REDACTED] refusal to cooperate with HSE plan

[REDACTED] advised that Mrs. [REDACTED] had been afforded considerable time to consider consenting to a voluntary move and had stated that any such move would cause her great distress.

iii. Day Service Attendance

[REDACTED] reported that following Mrs. [REDACTED] being confronted about SU1's poor attendance at ID1 Day Services, SU1's attendance had improved dramatically. [REDACTED] suggests that this meant that full attendance had always been under Mrs. [REDACTED] control.

iv. Suspicious Injuries

[REDACTED] advises that a report had been produced by ID1 Day Services containing "*much previously undisclosed information about concerns relating to (SU1's) previous attendances*" that in July 2008 SU1 had been observed by staff at ID1 Day Services to have scratches and marks on her back. [REDACTED] reports in his letter that "*the marks seem to be similar to carpet burns*". The letter also details the injuries which gave rise to admissions to the Accident and Emergency Dept on two occasions, in August 2008 and March 2009 and that the matter was under Garda investigation.

v. General Care

[REDACTED] advises of growing concerns around SU1's general appearance, including weight, old clothes, and untreated dental problems. SU1 had also been observed walking to the side entrance of the [REDACTED] house indicating that she might not normally use the main part of the home.

vi. Additional Concerns

██████ advises that another service user family at ID1 had informed staff that they would never use a particular respite placement, believed to be the ██████ due to the behaviour of the foster mother and the report from their child that he had been locked in a cupboard.

vii. Psychological Report

██████ advises that the Psychologist who re-assessed SU1 in late 2008 had stated that SU1 would have no attachment to Mrs. ██████ and therefore would not be adversely affected by a move to a group home.

viii. Placement

██████ advises that SU1 has a placement available to her through ID1.

4.11.15. Also on 22 April the ██████ requested a report from ██████ (PD1) re incidents and non attendances recorded on file for SU1.

4.11.16. On 27 April the VAC met. The Inquiry Team notes that the minutes of the VAC meeting of 27 April 2009 state as follows:

*"We are awaiting advice from Senior Counsel and ██████ has submitted an up to date report. ██████ is concerned that time is passing while there are ongoing concerns regarding her safety. (I (ID1 Day Services) feel that she is still unkempt. The Gardai are investigating the recent bruising on foot of a complaint from ██████ We are not sure which sector of the Gardai is involved. It is not clear if she is attending any medical/dental appointments at present. ██████ feels (SU1) should be moved to ID1 as soon as possible and has researched the legal position".*

4.11.17. On 14<sup>th</sup> May the ██████ wrote to HSE solicitors LA1 summarising information and requesting opinion on viability of an application for Ward of Court.

4.11.18. On 19<sup>th</sup> May, the ██████ wrote to the ██████ advising that initial indication pointing toward Ward of Court as the only option.

4.11.19. On 3<sup>rd</sup> June HSE solicitors LA1 wrote to the ██████ re proceeding to get senior counsels advice and suggested that he may meet with the HSE to review the files. Advised that it would be useful to have SUR1's consent to move

SU1 to a new placement and also consent for medical and other assessments as already indicated to the [REDACTED] (now Chair of the VAC).

4.11.20. On 9<sup>th</sup> June the [REDACTED] and [REDACTED] (PD1) met service user SU5 and a relative in relation to allegations made re Mrs. [REDACTED] locking him in a cupboard under the stairs when he was on respite with the FP's pre 2000.

4.11.21. On 23<sup>rd</sup> June HSE solicitors LA1 wrote to Senior Counsel (LA4) seeking opinion. The request was accompanied by the copy of the Barrister's opinion from Sept 2008, the report from [REDACTED] (it is unclear whether this was the updated report) and the original Boarding Out Contract with the FP's from 1989.

4.11.22. On 24<sup>th</sup> June [REDACTED] visited the Gardai. He is informed that SU1's file has been transferred to the [REDACTED] district Garda station for follow up. Also on this date H17 wrote a detailed commentary provided to both the [REDACTED] and [REDACTED] which sought to rebut details in the clinical file included by the [REDACTED] which she took issue with. H17 contested approx 29 references in SU1's file.

4.11.23. On 26<sup>th</sup> June HSE solicitors (LA1) wrote to the [REDACTED] [REDACTED] confirming having sent documentation to Senior Counsel and stating that their "*views and advices continue to be the same*".

4.11.24. The Inquiry Team understands that [REDACTED] made telephone contact with the birth mother SUR1 sometime between 27 March and 2 July 2009 to advise that SU1 had been admitted to A&E following bruising. On 2 July H17 returned a call to SUR1. SUR1 said she had been advised of bruising to her daughter SU1 by the [REDACTED] and wanted her daughter to be moved from the [REDACTED]. H17 advised the [REDACTED] of the above conversation. The [REDACTED] is recorded as having agreed that moving SU1 with her mother's consent would be the best approach as the legal advice he had received was that "*...going through the Courts may not be advised*".

4.11.25. There is a note of a telephone conversation on 3 July between H17 and SUR1, where SUR1 confirmed her consent to move her daughter from the [REDACTED]. Discussion took place around receiving advice on the appropriate consent wording to be utilised and H17 made arrangements to meet with SUR1 on her return to Ireland the following week. Discussion subsequently took place between the [REDACTED] and H17 about securing independent advice for the birth mother.

- 4.11.26. On 8<sup>th</sup> July a file note drafted by H17 outlines verbal communication from LA1 solicitors on their telephone consultation with Senior Counsel LA4. The advice Senior Counsel was that the HSE should not make an application for Ward of Court but should make an application to the High Court for placement for SU1 and this should be ASAP before the end of the Court season i.e. the end of July. The [REDACTED] was noted as being in agreement. The file note records that the meeting with the birth mother proceed and that she be encouraged to write a letter in her own words regarding her request for a residential placement in ID1 for SU1. On that same date the LA1 solicitor has indicated to the Inquiry Team that the advice he received was that an application was to be made to the High Court for the purpose of removing SU1 from the current placement [REDACTED] to a residential placement and that the "*Inherent Jurisdiction of the High Court was to be used to make such an application*". LA1 solicitor confirmed that Senior Counsel indicated that a Wardship application should not be brought in this case.
- 4.11.27. On 8<sup>th</sup> July LA1 solicitors wrote to the [REDACTED] indicating that it was the view of Senior Counsel that an urgent meeting was required with Senior Counsel so that he could move forward with the matter with a High Court application. A handwritten note from the [REDACTED] on that letter dated 13 July indicates "*hold for the moment*".
- 4.11.28. On 9<sup>th</sup> July H17 and [REDACTED] met the HSE solicitors LA1. It was decided not to meet with Senior Counsel at present. The plan was to:
- Meet with SUR1
  - Sign consent for Dental Treatment
  - Get letter from SUR1B re her daughter's future placement
  - H17 to set up placement and inform Mrs. [REDACTED] and ask her to bring SU1 in.
- 4.11.29. On 13<sup>th</sup> July H17 met with SUR1, who confirmed that she wanted her daughter moved "immediately" and furnished written consent to the transfer.
- 4.11.30. On 14<sup>th</sup> July H17 wrote to Mrs. [REDACTED] copied to the birth mother, ID1 staff, [REDACTED] and the [REDACTED] asking her to prepare SU1 for transfer on 24 July.
- 4.11.31. On 15<sup>th</sup> July H17 telephoned Mrs. [REDACTED] who advised she had not received the letter sent on the 14<sup>th</sup>. The file note

indicated that Mrs. [REDACTED] did not want to meet if it was in relation to moving SU1.

4.11.32. 16<sup>th</sup> July – A telephone call between H17 and Mrs. [REDACTED] requested she keep SU1 for a further two weeks in order to take her on holidays. H17 was concerned that there would be no access to SU1 if she went on holidays with Mrs. [REDACTED] and it was agreed to approach the birth mother again to outline options to her. This approach was made the following day and the following options were put:

- 1) Leave SU1 with Mrs. [REDACTED] until after the holidays
- 2) Move on 24<sup>th</sup> as planned
- 3) Move today as placement is ready

The birth mother requested that her daughter be moved immediately and the following actions were taken by the H17:

- H17 discussed with [REDACTED] and everything was in place for the move
- [REDACTED] advised to make formal request to ID1 to move SU1
- H17 went to ID1 Day Services to facilitate move. SU1's care plan discussed and needs outlines
- Arrangements were made to contact Mrs. [REDACTED] along with her GP and G in order that all would be aware of the move
- Spoke with Mrs. [REDACTED] and advised that her request was considered but SU1's birth mother wanted her to move immediately. Informed her that SU1 would move from day service to her new residential placement
- Spoke with [REDACTED] at ID1 and asked her to phone Mrs. [REDACTED] on Monday. [REDACTED] had made contact with SU1's personal advocate.

4.11.33. On 17<sup>th</sup> July SU1 was transferred to ID1 residential placement, which was one week in advance of the planned move for 24<sup>th</sup> July. The [REDACTED] (PD2), who had been the principal contact in respect of the transfer, was on annual leave. The transfer took effect, accompanied by a handwritten letter from H17 to the [REDACTED]. This letter was subsequently typed and issued. These circumstances became the subject of a complaint from the Independent Advocate from the local Citizens Information Centre on 28 September 2009. Such circumstances are described as follows:

- That SU1 left her care placement on the morning of 17<sup>th</sup> July as per her usual routine to attend Day Services at ID1 and that instead of being returned to the foster placement, was transferred to a residential setting within ID1
- That the [REDACTED] (PD3) and the [REDACTED] (PD2) were on annual leave at the time

- SU1 was not prepared for the move and all of her personal items remained in the [REDACTED]
- SU1 had not visited the residential service prior to her admission and was not afforded the opportunity to meet the other residents prior to transfer
- It is alleged that the HSE did not make any attempt to communicate directly with SU1 in relation to the transfer.

H17 has stated to the Inquiry Team that she proceeded with this action on the basis of:

- A very concerning phone call with the former foster mother
- The fact that there would be no contact with the Day Service and therefore no daily monitoring of the client
- The wishes of the birth mother
- Legal action may take some time
- Recent bruising and concerns
- Lack of information/feedback from Gardai
- Written opinion of PD3 and [REDACTED]

4.11.34. On 20<sup>th</sup> July H17 reports that she had contact with [REDACTED] (PD1) who reported that SU1 had settled in to her new placement. On 24<sup>th</sup> July the [REDACTED] also reported that she attempted to make contact with Mrs. [REDACTED] who had gone to stay at her sisters' for a few days, and contact was also made with Mrs. [REDACTED] General Practitioner to update him on the situation.

4.11.35. On 28<sup>th</sup> July the HSE solicitors (LA1) wrote to the [REDACTED] suggesting that as regards Senior Counsel who had provided verbal advices, "*we do not require further advices in this matter*". This was agreed to by the [REDACTED] on 29<sup>th</sup> July.

4.11.36. On 18<sup>th</sup> August, the [REDACTED] (PD1) provided a comprehensive report to PD3 regarding SU1's absences from Day Services over a period of years.

4.11.37. At some point in August the [REDACTED] informed the Gardai that SU1 had moved into residential care.

4.11.38. On 24<sup>th</sup> August H17 met with the [REDACTED] and agreed the need for a care meeting to take place. [REDACTED] advocated an



inquiry into the [REDACTED] as foster carers and also stated that the HSE needed to find a process to deal with concerns.

4.11.39. On 2<sup>nd</sup> September H17 and [REDACTED] met with ID1. [REDACTED] is reported as having expressed the view that he was of the opinion that an application for Wardship was the best course of action for SU1. The [REDACTED] is also reported as saying that he believes that in his professional opinion that SU1 was sexually abused in the [REDACTED] care and recommended an invasive examination of SU1 to assess this. In subsequent correspondence on 15<sup>th</sup> October 2009 the [REDACTED] (PD1) states that ID1 asked about "*the proposed investigation by the HSE*" of the following issues;

- The allegation of physical abuse made by SU5 against Mrs. [REDACTED]
- The suspected fraudulent handling of SU1's finances by Mrs. [REDACTED]
- The many welfare concerns for SU1 relating to her placement with Mrs. [REDACTED]

4.11.40. On 4 September [REDACTED] confirms to H17 that [REDACTED] is not currently subject to a Garda investigation. He advises that the G are investigating how SU1 came by her bruising. [REDACTED] states that he will follow up with G.

4.11.41. On 14 September there is a VAC meeting and it recorded that there was no response from G. It is also recorded that a letter of thanks is sent from the HSE to the [REDACTED] (PD2) and the [REDACTED] (PD1) for their cooperation in SU1's transfer.

4.11.42. On 16 September the [REDACTED] provided a comprehensive response to issues raised by H17 on 24 June 2009 regarding references on file by [REDACTED] concerning the [REDACTED] role the SU1 case.

4.11.43. On 18 September the [REDACTED] (PD1) wrote to H17 seeking to confirm her understanding from the [REDACTED] that no additional funding would be provided in respect of SU1.

4.11.44. On 28 September a complaint on behalf if SU1 is made by the Independent Advocate from the local Citizens Information Centre in relation to the circumstances of SU1's transfer from her foster placement (see para 4.11.33 above).

4.11.45. On 5 October a care planning meeting took place attended by [REDACTED] the Citizens Information Advocate, the [REDACTED] and the [REDACTED] from

██████████ (SP2), and other ID1 residential services staff. The meeting noted that Mrs. ██████ had not contacted the HSE to request contact with SU1 and no contact had been sought through ID1 since SU1's admission to residential services in July 2009.

4.11.46. On 15 October a comprehensive letter was issued from the ██████████ to H17 outlining ID1's understanding of the content of discussions at a meeting of 2 September in response to a letter from H17 dated 14 October confirming that the funding of additional needs for SU1 where identified would be met and that matters would be progressed by the Vulnerable Adults Committee. The letter of 14 October also sought details of the legal advice received by ID1 with regard to capacity and consent and suggested sharing advice so that ID1 and the HSE could best work together to meet the needs of this and other clients.

4.11.47. On 19 October the ██████ met the Gardai in the ██████ locality to discuss allegations against the ██████. The Garda advised that they had formed a view that the bruising to SU1 had probably been caused by being lifted from the bath. There is no indication on file as to how the Garda arrived at that view. ██████ notes that he advised the Garda that SU1 was fully ambulant and would not have required the assistance as suggested.

4.11.48. On 20 October in the course of a meeting between ██████████ H17, and ██████ ██████████ and ██████████ it is stated by ID1 that they have made a Ward of Court application for SU1.

4.11.49. On 20 or (29 October) A VAC meeting took place and it is noted that issues discussed were Garda investigation re alleged injuries update and reported sexualised behaviour from SU1 at ID1. The Inquiry Team notes that at the VAC meeting of 20 (29?) October 2009 (attended only by H17, ██████ and H20, the following was minuted:

- An updated report on ██████ liaison with Gardai re issues which led to SU1 attending SATU1 in March 2009.
- That ID1 had reported incidents of sexualised behaviour on the part of SU1 following her transfer to residential services.
- That a decision was requested on any outstanding obligations to investigate historical allegations re the ██████ placement

4.11.50. On 3 November the ██████████ wrote to the ██████████ and confirmed that the HSE was seeking legal advice around capacity and consent issues re SU1

and further states... *"It is my view that our action/application to appoint a Committee of the Person, to (SU1) should be taken by the HSE as the state agency with overall responsibility for SU1's care at this point in time. I do not consider that it would be appropriate for (ID1) as an agent of the HSE (in terms of SU1's care) to act in isolation of the HSE as their main funder" ... "Accordingly I will be asking our legal advisors to prepare and submit an application for Wardship specifically in the context of clarity on capacity and consent. I would suggest that (ID1) might await the outcome of that application".*

4.11.51. On 10 and 12 November correspondence is exchanged between ID1 and LHO1 with ID1 advising that they were proceeding with Ward of Court application and LHO1 advising ID1 that they take no further action on the application. The LHO1 subsequently contested that it had made that suggestion and stated that ID1 may have been requested to *"desist from such an action pending receipt of appropriate legal advice from both parties"*. Correspondence also disputes whether there was any inference that ID1 proceeding with the Ward of Court application would have implications for the funding relationship between ID1 and the HSE. Any such inference is subsequently refuted by the [REDACTED] in a letter dated 3 December 2009 to ID1.

4.11.52. On 12<sup>th</sup> November the [REDACTED] established a working group to look at historical issues highlighted around concerns by service users on placement with the [REDACTED]. The group consists of the [REDACTED] H17, [REDACTED] [REDACTED] (PD3) and the newly appointed [REDACTED] (H28). [REDACTED] (PD3) did not attend the meeting because of prior industrial relations issues between him and the newly appointed [REDACTED].

4.11.53. Also on 12 November PD1 and PD2 wrote to the Office for the Minister for Health and Children following initial telephone contact. The letter proposes a meeting with the Department of Health and outlines *"concerns and allegations of abuse that we are aware of in (the [REDACTED] placement) ranging from chronic neglect to sexual abuse...we are also writing in relation to the local [REDACTED] HSE Office/Disability Team's failure to address these issues and apparent attempts to cover up the situation. There has also been failure on the part of G to investigate alleged sexual and physical assaults."* The letter also alleges that ID1 had been advised off the record that [REDACTED] (PD3) and H21 *"...have copied their files in relation to this case as they fear they will be destroyed or tampered with"*. The letter to the Office of the Minister also attached the letter from

ID1 to the H17 dated 15 October 2009 with names of the service users and of the [REDACTED] redacted. The Inquiry Team understands that that correspondence was forwarded by the Office for the Minister for Children and Youth Affairs to the Consumer Office of the HSE requesting that the HSE investigate the issues raised in accordance with *Children First* Guidelines. The Consumer Affairs Office forwarded the documentation to H17 and LHO1 seeking advice on where to send the documentation for investigation. Correspondence then issued from H17 to the Consumer Affairs Office. It is also reported that the Child Welfare and Protection Policy Unit advised that the Minister for Health and Children was interested in the case and that she was to be advised of the response and what action if any was being taken. The Consumer Affairs Office then wrote to PD1 and PD2 advising them that H17, LHO1 "*would deal with it as she sees appropriate*". In this manner the representations by PD1 and PD2 came to the attention of senior staff within LHO1. Both PD1 and PD2 subsequently queried the handling of their representation by the Department of Health. The Inquiry Team understands that this sequence of events led to significant correspondence between PD1 and PD2 and the Department of Health and also led to PD1 and PD2 deciding to make a disclosure under the Protected Disclosures Provisions of the Health Act.

4.11.54. On 13 November the [REDACTED] (PD1) requested information from H17 on SU1's former carer to inform her care plan to be provided to the Consultant [REDACTED] attending SU1. That correspondence also details SU1's "*high anxiety and the apparent emotional trauma*" caused by the "*sudden move*" and indicating that the Consultant [REDACTED] had recommended some supervised contact with Mrs. [REDACTED]

4.11.55. On 13 November 2009 the [REDACTED] advises that a Psychologist from ID2 had recommended that SU1 be interviewed re her experiences in the [REDACTED]. On this date PD3 advises H17 that he has sent to [REDACTED] (PD1) a report regarding the [REDACTED] placement. As far as the Inquiry Team can establish, this is the first formal communication of historic concerns in respect of SU1 and other service users in relation to the placement.

4.11.56. On 30 November a home visit by PD3 to Mrs. SUR3 took place as arranged by phone. Another daughter was also present. PD3 updated them regarding his investigations and informed them that he had recommended a further investigation by senior HSE people outside HB3. The note of the meeting details the suspicions on the part of the service user's

mother regarding possible sexual abuse and recounts the outcomes of consultations with medical staff regarding those suspicions.

The Inquiry Team understands that neither H17 or H25, or any member of the working group established on 12 November 2009 in relation to historic issues, were notified of this meeting.

4.11.57. On 17 November a VAC meeting was due to take place but did not, due to lack of number attending and on 19 November there is a note indicating that there were no future meetings planned for the VAC.

4.11.58. On 26 November in a "without prejudice" memorandum from the [REDACTED] (H26) to the [REDACTED] (H23) reference is made to the notification submitted to the Department of Health and Children by PD1 and PD2. The memorandum is stated to be a preliminary response to the notification submitted and was prepared without detailed reference to all the necessary files. The memo also indicated that a further more comprehensive report would be prepared. The detailed memorandum provides a summary of the [REDACTED] understanding of the position at that point in time:

- *"(SU1) is in a safe placement at this point*
- *There are no other clients placed by HSE with (Mrs. [REDACTED]) at this time*
- *There is no intention on behalf of the HSE to make future placements here.*
- *The HSE is not aware of any further vulnerable client in (Mrs. [REDACTED]) care*
- *There is/was no cover up of the situation*
- *There is no threat to the integrity to the files in this clients case*
- *The funding arrangement is not compromised (for ID1)*
- *Legal advice is being actively pursued by HSE in regard to this client"*

.... *"I should raise my concerns around the potential breach of confidentiality, on the basis of documentation which may have been given to staff of (ID1) and which may or may not relate to clients of that organisation."*

- 4.11.59. On 10 December PD3 learns that a letter has been sent by PD1 and PD2 to the Department of Health on this case.
- 4.11.60. On 23 December the LHO solicitors (LA1) confirmed to the ID1 solicitors that the HSE was nominating H17 as its nominee on the Committee as part of the Ward of Court application process. Both ID1 and its legal advisors took issue with the nomination and accordingly this nomination was not accepted.

4.12. **Key Events in the period January 2010 – March 2010**

- 4.12.1. On 4 January ID1 solicitors (LA5) confirm that the birth mother SUR1 did not wish to put herself forward as Committee as part of the Ward of Court process.
- 4.12.2. On 5 January, H17 and [REDACTED] met to discuss outstanding issues re SU1 and H17 requests update re possibility of vulnerable adults staying with the [REDACTED]
- 4.12.3. On 6 January [REDACTED] wrote to the Gardai to enquire whether they have information about another vulnerable adult (SU6) staying with Mrs. [REDACTED]
- 4.12.4. On 13 January PD1 wrote to [REDACTED] on behalf of SUR1 with 15 questions to be answered concerning the care of SU1. Also on this date the [REDACTED] wrote to the [REDACTED] stating for the record that there were entries in the SU1 file which did not represent the situation clearly and set out a series of clarifications.
- 4.12.5. On 15 January a case conference in ID1 was held re SU1. The attendees, including the [REDACTED] and [REDACTED] (H25) were informed of separate care planning group established in HSE, some disquiet was expressed re proposal for a separate assessment of SU1 by an external [REDACTED] (SP4). The notes of H17 state that the HSE legal rep has made contact re joint Wardship application and H17 is nominated as one of the Committee. Actions were noted as [REDACTED] to follow up with [REDACTED] re table of allegations, interviews with SUR3 family.
- 4.12.6. On 19 January costings were sent from ID1 to HSE re SU1
- 4.12.7. On 20 January [REDACTED] (SP3) submits report on SU1.
- 4.12.8. On 26 January [REDACTED] PD3 refuses request from the [REDACTED] to tabulate known allegations on the grounds that it "*trivialises the matter*".
- 4.12.9. On 28 January the [REDACTED] emailed [REDACTED] re the above refusal.
- 4.12.10. On 29 January a case note details discussions with the [REDACTED] and external service provider ID2 re vulnerable adult SU3. It is noted that ID2 had concerns re using the [REDACTED] as

placement and had raised this with the Health Board in 1991. Those concerns centred on two issues which are stated as *"firstly that there was another person or more than one person living in the placement who was not identified to the (ID2 service provider) by the [REDACTED] and secondly that this had been raised as an issue with the [REDACTED] and the (ID2) felt that they had been misled by the [REDACTED]"*. It is also noted that the ID2 [REDACTED] indicated a recollection of some general concerns re the placement and specifically *"about the number of children in the placement"*.

- 4.12.11. On 1 March SU1 admitted to Wardship by order of the President of the High Court. The file shows significant correspondence in the lead up to the Wardship application involving the LHO1 and its legal advisors and ID1 and its legal advisors around the appropriate make up of the Committee of the Person. The HSE nominated one of its employees to sit on the Committee. Both ID1 and its legal advisors took issue with this nomination. The outcome of the Ward of Court proceedings resulted in PD1 becoming the sole committee member. HSE files indicate that HSE senior management were advised of this detail, by letter from their legal advisors (LA2) dated 1 April 2010.



## **5. Findings re Key Care and Service Delivery Issues 1978 to 1997**

### **5.1. *Introduction***

5.1.1. The findings set out below have been arrived at having regard to the comprehensive review of all files, the interviews undertaken, correspondence with individuals who did not attend for interview, and all documentation tabled around the protected disclosures. As the Inquiry covers a period of over 30 years, the findings have focussed on the key care and service delivery problems, the service delivery factors which contributed to those problems and the resultant consequences for the service user SU1 in particular. These findings are based on the chronology of key events (Section 4), extracts of which were distributed to interviewees and other interested parties for comment. The findings were distributed in redacted format to all relevant parties; any comments received were taken into account in finalising the findings set out below in sections 5 and 6.

5.1.2. The core of the concerns which formed the basis of the protected disclosure made by two staff members (PD1 and PD2) employed in the health agency (ID1), centres on their concerns surrounding the management by the HSE and its predecessor, the relevant Area Health Board, of service user SU1. There are also consequential issues arising from the expression of those concerns which principally focus on the significant deterioration in working relationships between the ID1 agency and the Local Health Office of the HSE (LHO1). A further consequential issue of concern raised by the disclosers has been the circumstances under which the disclosure was made in accordance with the provisions of Part 14 of the 2007 Health Act, having first been the subject of correspondence with the Office of the Minister for Health and Children.

5.1.3. The second protected disclosure, from a HSE staff member and [REDACTED] (PD3), consists of the tabling of a report which had been drafted by that discloser in 2009 for the purposes of obtaining legal advice, principally relating to the care of service user SU1. That documentation also referred to concerns on the part of PD3 about the appropriateness of the foster placement where SU1 was resident with FP1 from 1989 to 2009, with reference to concerns specific to SU1 and wider concerns in respect of the placement. Those wider concerns centred on PD3's

understanding of reports of the experiences of others in that placement. While the Inquiry Team has examined all documentation on record in respect of those other service users, those circumstances have been examined with a view to establishing whether it was known, or ought to have been known, that there were recorded concerns in respect of the foster placement. It is not within the terms of reference for the Inquiry Team to establish whether alleged abusive interactions took place in the relevant foster placement. However it is a matter for the Inquiry Team to have regard to whether the relevant authorities who had responsibility for initially contracting the foster placement and continuing the residency of SU1 in that placement, discharged statutory, best practice, and duty of care obligations in accordance with the standards and obligations that applied over the 30 year period under review.

## 5.2. ***Pre 1989***

- 5.2.1. The available files from the period 1978 – 1989 reflect clear planning and decision making around the care of SU1 on the part of Health Board HB1. This included the admission of SU1 for residential care while an infant and preparations for foster placement in that Health Board area in accordance with the Boarding Out of Children Regulations 1954-1983. The foster parents were assessed, the placement itself was monitored on an ongoing basis in accordance with the regulations and SU1's birth mother's consent was obtained for the fostering arrangement. It is noted that continuing responsibility for SU1 was assumed by the Health Board where the birth mother was originally domiciled (HB3). This is evident from the approval being sought and provided by the [REDACTED] (H1) from the birth mother's Health Board area for the fostering arrangement.
- 5.2.2. The Inquiry Team notes that where there were any care or service delivery problems in the time period in question, such issues were documented, as were the actions taken to address those concerns. Unfortunately due to domestic and ill health difficulties on the part of the foster parents, fostering arrangements began to break down and the decision was taken by the [REDACTED] for the relevant Community Care area in HB1 that foster care could no longer be provided in that setting. As a result, SU1 was transferred to HB3 where the [REDACTED] (H1) indicated that "short term" foster care

would be sought for SU1 along with longer term residential accommodation within HB3.

### 5.3. ***The period 1989 – 1996***

5.3.1. The Inquiry Team notes that in February 1989 formal arrangements were made with foster mother [REDACTED] through a form of Contract for Child Boarded Out in accordance with the 1954 regulations. It should be noted however that the 1983 regulations were in place at that time. While there are seven diary entries of visits by [REDACTED] H1 to the placement in 1989, there is no evidence on file of any other measures in accordance with those regulations being carried out including:

- No evidence of an assessment of the applicants' suitability for fostering
- No evidence of references being obtained re the foster parents
- No evidence of a documented visit by the Health Board to determine the suitability of the home environment prior to the placement being confirmed
- No documented first two month visit as required under the regulations. (see Section 4.3 above for further details)
- No evidence of experience as a Foster Parent in the UK being checked or confirmed despite such experience being indicated on file. It is noted that the former foster mother (Mrs [REDACTED]) has advised the Inquiry Team that she had previous experience in the UK as a registered child minder but no previous experience as a foster parent.

5.3.2. The Inquiry Team notes that a school place was reserved for SU1 in mid December 1989 but only availed of for a matter of weeks. There is no evidence that the reasons stated for non attendance, i.e. transport difficulties, were followed up by the Health Board, with no alternative plans for transport or other school arrangements recorded on file. A further five years elapsed before other services, i.e. day services, were put in place for SU1. Although there is evidence on file that an alternative residential placement for SU1 was explored in 1992, this was not concluded and what was a formal placement for SU1 under the 1954-1983 regulations was not effectively regulated or monitored. The lack of recorded activity in this period and the consequential absence of planned activation, education and socialisation for SU1, suggest a failure by the Health Board (HB3) to discharge duty of care responsibilities toward SU1 in the period 1989 to 1994 inclusive. There is also a

self evident failure to discharge assessment and monitoring obligations in respect of the foster placement as required under the 1983 Boarding Out of Children Regulations.

5.3.3. The Inquiry Team notes that a fostering social work service was introduced in that Health Board area (HB3) in 1994. It would be reasonable to conclude that the introduction of this service and the involvement of [REDACTED] (H8) and [REDACTED] (H4) contributed to a more focussed approach from the Health Board on its responsibilities to SU1. This approach included requesting a medical report, a consultation with an Ophthalmic Physician, and a Psychological assessment. Arrangements were made with ID1 Day Services, and contacts made with the [REDACTED] to agree to the day services arrangement. Although 1995 can be characterised as a period within which the Health Board (HB3) discharged a number of core, statutory and duty of care obligations to SU1, the Inquiry Team would be concerned that other aspects of SU1's care do not appear, on the basis of the evidence available on file, and from interviewees, to have been adequately pursued. These concerns would include:

- The continuation of the placement on the basis of a voluntary care order rather than giving consideration to an application for a full care order, reduced the potential flexibility of the Health Board to make timely decisions in the interest of the Service User SU1
- The absence of any transitional planning for the foster placement coming to an end in 1996 (when SU1 was due to reach 18 years of age)
- There was a lack of documented action to address the stated concerns from early 1995 on the appropriateness of the placement for SU1
- There was no evidence of documented follow up on reports of bruising to SU1 emanating from ID1 Day Services in 1995.
- There was a lack of evident planning around future and ongoing communications with SU1's birth mother.

#### 5.4. **1996**

5.4.1. Despite an in-depth examination of all files relating to decision making around SU1 and the foster placement in 1996, the Inquiry Team has not been in a position to establish a clearly documented rationale for key decisions taken concerning SU1 in that period. The circumstances giving rise to the attempted interventions by the Health Board in 1996 are detailed in section 3.4 above. It has been suggested to the Inquiry Team that a notification file and diaries would have

assisted in establishing the rationale for decision making at that time but these could not be located. The Inquiry Team also interviewed all available individuals who would have participated in case conferences held in 1996 and who would have had an involvement in dealing with issues raised in respect of allegations made by the mother (SUR2) of another service user (SU2) regarding SU1's foster placement and the processing of objections by the foster parents to the Health Board's attempts to remove SU1 from the foster placement and place her in residential services. While those interviews assisted in establishing some context around documentation on file, the rationale for the key decision of that period not to remove SU1 from the foster placement cannot be established as a matter of fact. There are however a number of issues that can be established having regard to the information available and these are set out in paragraph 5.4.2 below.

5.4.2. Participants in the second case conference regarding SU1's foster placement in 1996 (24 October 1996, see para 3.4.15 above) have provided divergent and diverse recollections as to where the decision not to remove SU1 from the foster placement emanated from. In some cases the recollection was that the decision not to remove was as a result of a successful appeal by the [REDACTED] of the decision made at a previous case conference on 23 April to remove SU1 from the placement in accordance with the new 1995 Child Care Regulations. The Inquiry Team, on the basis of the evidence available, would be of the view that the two persons designated to hear the representations made by the [REDACTED] did not uphold the appeal of that decision. The Inquiry Team would also be of the view that the decision taken at October's case conference to effectively reverse the outcome of the April case conference was taken by the professionals concerned including the [REDACTED] [REDACTED] (H7), [REDACTED] (H6), and the [REDACTED] (H4). It is not clear however if this decision was made prior to the October case conference or was taken at the case conference. The consequences for SU1 were that the placement with the [REDACTED] continued beyond her 18<sup>th</sup> birthday as an ad hoc placement with minimal intervention and monitoring for a further twelve and a half years.

5.4.3. The Inquiry Team would be concerned that the actions and apparent omissions on the part of the professionals involved in 1996 were directly connected to SUI's continued placement with the [REDACTED] as follows:

- The decision to establish a team to hear representations under Article 22 of the 1995 Child Care Regulations regarding the removal of SU1 from the placement did not include the establishment of Terms of Reference for the team
  - There is an absence of clarity in respect of the decision-making process following the hearing of representations by the Article 22 Team and a similar lack of clarity as to how recommendations made by that team would be notified to the decision-maker within the Health Board and to those making representations
  - There is an absence of a documented decision by the Article 22 Team following the hearing of representations from the [REDACTED] around the removal of SU1 from the placement
  - There is an absence of a reference on the record of a Case Conference in October 1996 on reasons why the decision re removing SU1 from the foster placement of the original Case Conference in April 1996 was being reversed
  - There is an absence of documented evidence as to how the concerns stated in the April case conference regarding SU1's welfare and wellbeing were subsequently satisfactorily assessed so as to inform the conclusion reached in the October case conference that *".....there is no evidence that anything happened to SU1 or that her wellbeing or welfare are not being met by the [REDACTED]"*
  - There is an absence of clarity as to why the HB3 ceased the referral of children for placement with the FP1's in 1996 but continued SU1's placement
  - There is no evidence of contact being made with SU1's birth mother around the decision to remove SU1 from the placement and the reversal of that decision
  - There is no evidence of follow through of decisions made at the Case Conference in October 1996 despite the appointment of a Key Worker to "monitor" the case
  - There is no evidence that legal opinion was sought in respect of any aspects of decision-making around SU1 in 1996.
- 5.4.4. The Inquiry Team separately corresponded with the HSE making specific recommendations that the HSE would address a number of specific questions relating to a different service user (SU2) arising from the examination by the Inquiry Team of files relating to this period.

## **5.5. 1997 – 1998**

5.5.1. The transfer of responsibilities for SU1 on reaching age 18 from the Foster Care Team to the Adult Learning Disability Service did not lead to any evident follow up by the designated [REDACTED] (H12) of the decisions made by the October 1996 case conference. The designated [REDACTED] began job sharing in June 1997 and the Inquiry Team has been advised that responsibility for SU1 transferred to the [REDACTED] (H13). The absence of any effective hand over or transfer and the lack of any designation of SU1 as being a priority case resulted in little or no activity or interventions relating to SU1 by Health Board professionals in the years 1997 – 1998. On the basis of the files seen by the Inquiry Team, there is documented evidence of only 2 Home Visits carried out in 1997, with the first of these occurring in Feb 1997, some 4 months after the October 1996 Case Conference and the second visit is recorded as occurring in June 1997. The Inquiry Team did not see any evidence of a Home Visit occurring in 1998. This lack of activity, in the view of the Inquiry Team, represents a failure to discharge duty of care responsibilities to SU1 in that period.

## **5.6. 1999 – June 2001**

5.6.1. The Inquiry Team would note that the period 1999 – 2001 featured a number of attempted interventions on the part of [REDACTED] (H14) who was appointed to Disability Services in early 1999 and departed in June 2001. H14's post was a part time one and was part of a new job sharing arrangement for the former identified [REDACTED] for SU1 (H12). Notwithstanding the more focussed interventions attempted by H14, there were a number of care and service delivery problems encountered by H14 in discharging responsibilities toward SU1. These are summarised in the bullet points below:

- The Inquiry Team understands that the newly appointed [REDACTED] H14 visited the [REDACTED] with [REDACTED] H13. An introductory phone call to Day Services was also conducted. In the course of that telephone call the [REDACTED] [REDACTED] outlined a series of concerns re SU1 which are summarised in paragraph 3.6.3 above
- Because of failure to plan for ongoing communication with the birth mother, there was uncertainty around contact details

when attempts were made to approach the birth mother for consent to move SU1 to a residential placement. Difficulties in making contact with the birth mother led to direct contact from the [REDACTED] (H14) with the birth mother's family through correspondence, where SU1 was referred to by name. This form of contact may have contributed to the birth mother's initial reluctance to agree to the residential placement offered which was located in the town where the birth mother's family resided. It is acknowledged by the Inquiry Team that both [REDACTED] H14 and the then [REDACTED] H15, persevered with identifying the then residential placement and obtaining the consent of the birth mother for the transfer to residential care.

- The Inquiry Team would be of the view that [REDACTED] H14's interventions up to this point led to a greater sense of urgency around the securing of a residential placement for SU1. However that sense of urgency would appear to have dissipated from early 2000, seemingly due to concerns around obtaining the birth mother's consent to the move toward a planned transition to residential care. The Inquiry Team notes that, for example, on the basis of the documentation examined, there is no recorded Home Visit to the foster family in the year 2000. It is unclear to the Inquiry Team as to what the basis was, from a legal or from a best practice perspective, for the consent issue being perceived as the main obstacle for following through on the decision to implement a planned graduated move to residential care. There is no record on file of any such legal advice being obtained at that time or any other decided cases being referred to as a basis for the supposition that the consent of the birth mother was required for the transfer. Neither is it clear if consent was required as a prerequisite for admission to residential placement. This delay in following through on the verbal notification to the [REDACTED] in September 1999 of the Health Board's proposal to place SU1 in residential care, had significant consequences for that residential placement proposal. The proposal was scheduled to be formalised at the Professionals meeting in early 2001 following receipt of the birth mother's consent in December 2000.

5.6.2. The key formal decisions relating to SU1's care during the period 1999 – 2001 relate to two Professionals meetings in February and March 2001. The first Professionals meeting in February 2001 considered reports from Day Services and from [REDACTED] H14, and on the basis of those reports, decisions



were made around a phased transition to residential care over a period of approximately eleven months with a review and monitoring system in place, and that if there was no movement by January 2002 that the Health Board would consider legal action e.g. Wardship. This decision was made without the benefit of a home visit to the [REDACTED] for approximately seventeen months. In that period (June 2000) Mr. [REDACTED] had died and Mrs. [REDACTED] was now caring for SU1 alone, as well as caring for her thirteen year old grandson. During that period however SU1 continued to be collected on a daily basis and transported to Day Services with no apparent communication with Day Services that one of the two carers had died. The failure to continue to adequately monitor the placement for a period of seventeen months in circumstances where the Health Board had concluded that the placement was not suitable for SU1's needs is difficult to understand. The consequences of the failure to monitor led to the Professionals meeting of February 2001 arriving at conclusions which did not take into account up to date facts concerning the placement, which had the effect of halting the momentum which had built up largely through [REDACTED] H14's efforts to secure alternative residential care for SU1. The Inquiry Team notes from the minutes of the first Professionals meeting that discussion arose around the allegations from another service user SU2 which emerged in 1996. The minutes of the Professionals meeting indicate that the [REDACTED] (H6) stated that "*...previous allegations were dealt with and cannot now be resurrected...*" The Inquiry Team wishes to record its understanding that these allegations were not dealt with at the time as no substantive investigation into those allegations took place on the part of the Health Board. The Inquiry Team notes that a named Garda was nominated to review the specific allegation but that this investigation did not proceed, reportedly due to the unwillingness of the parent of the young girl to allow for her daughter to be interviewed. The Inquiry Team acknowledges however that the unresolved issues in respect of the allegations made by the mother of SU2 were not required to be considered by that Professionals meeting to reach a conclusion on the suitability of the placement for SU1's needs given that it had already been established that:

- The advancing age of the carers, first identified in 1995, was no less an issue six years later with one of the carers being seriously ill, (in accordance with their most recent information of September 1999)
- The birth mother had consented to the move toward residential care both verbally and in writing and that Mrs. [REDACTED]

had indicated in September 1999 that she would only accept SU1 moving if the birth mother put it in writing that she no longer wished SU1 to stay with the [REDACTED]

- Day Services had reported frequent absences from its service by SU1 for long periods and that the FP's had never availed of respite care or the annual holiday arranged by the Day Service for service users
- The lack of opportunities for social interaction with peers, the geographical isolation of the placement and the travel time between the placement and Day Services were not conducive to meeting SU1's needs.

5.6.3. In light of the belated information concerning Mr. [REDACTED] death some eight months previously, a second Professionals meeting took place on 21 March 2001. That meeting included consideration of a request by Mrs. [REDACTED] to retain SU1 in the placement for a further 5 years. This meeting again decided to proceed on a phased basis to move SU1 to a Community House Monday-to Friday and remain with Mrs. [REDACTED] at weekends. The Inquiry Team notes that arrangements were made with the residential placement but this was resisted by Mrs. [REDACTED] who wrote to ID3 in May 2001 advising that SU1 would not be taking up the placement. ID3 sought advice from the HB3 on this refusal and was advised by outgoing [REDACTED] that both she (H14) and the [REDACTED] (H15) were leaving their posts and the matter would "*hopefully be taken on board by the next Coordinator for Disabilities.*" There is no indication that the actions decided upon by the second Professionals meeting to move SU1 to residential care on a phased basis were followed through. There is some suggestion contained in correspondence that there was a legal difficulty with the proposed move. The Inquiry Team has not had sight of any documented reason for not putting this decision of the Professional's meeting into effect.

## 5.7. **June 2001- August 2007**

5.7.1. Given the highly unusual events surrounding the Professionals meetings in February and March 2001 and the troubled background relating to the previous attempt to transfer SU1 to a residential placement, the Inquiry Team would be of the view that it would have been reasonable to expect that SU1 would remain a priority for Disability Services within the Health Board. The Inquiry Team has sought to establish whether there was any system in place to identify

priority cases and to follow through on such cases in 2001. SU1's name did appear on a priority list which the incoming [REDACTED] (H17) had compiled. It is not clear to the Inquiry Team what the criteria was for compiling the priority list and what significance is attached to being on the list. H17 has stated that a number of high priority clients were identified to her by the outgoing [REDACTED] (H15) but that SU1 was not verbally identified as a client with priority needs. The Inquiry Team notes that there are substantive differences in accounts between the outgoing and incoming [REDACTED] as to the level and detail of any handover (see para. 6.10.5 below). In submissions made to the Inquiry Team, H17 has acknowledged that there "*may have been systems failures in the way information was shared when I came in to post*"

- 5.7.2. The Inquiry Team has serious concerns regarding this entire period of just over six years where despite opportunities to follow up on the Professionals Meeting proposals and the available residential care option, these were not availed of. While the absence of a designated [REDACTED] for a period of approximately twelve months may have been a contributory factor for the inactivity around SU1 for that period, Senior Management including Social Work and Disability Services had a continuing responsibility to ensure that priority cases would be followed up and recorded decisions made at Case Conferences and Professionals Meetings implemented. The Inquiry Team notes that H17 is adamant that she was not notified of concerns regarding SU1's placement. H17 in submissions to the Inquiry Team has stated that while SU1 had been identified as a priority for funding and placement earlier in 2001 there were "*...other indicators that are not fully consistent with this or that what might lead one to believe that the situation had become less urgent*". H17 detailed such indicators as including, a letter from the [REDACTED] indicating "no immediate danger", indications from ID1 Day Services that SU1 was happily placed with Mrs [REDACTED] and that ID3 were "*satisfied to replace SU1's placement with that of another client*". The Inquiry Team notes that in the period July/August 2001 a decision was made by the [REDACTED] (H17) to correspond with the proposed residential placement (ID3) to advise that SU1 would not be availing of residential care "*right now*". H17 states that she was in a position to so advise on the basis of information provided by the [REDACTED] of the residential facility, that [REDACTED] H14 had confirmed this in writing to the residential facility. H17 has advised that she did not see that letter from H14 dated June 26 2001 until 2007 and she did not identify any

pressing need to review SU1's file. H17 has further stated that given that H17 had only recently arrived in the post, reliance was placed upon colleagues to provide relevant information that would prompt H17 to follow up as appropriate. It is noted that H17 states that H17 did not read the SU1 file (and states that it would not have part of H17's duties to review client files) and there is no evidence of input to the decision not to avail of the residential placement from any of the professionals involved in either of the Professionals Meetings which had taken place earlier in 2001. Many of those professionals remained in the Health Board and ought to have been available to clarify any issues around the care of SU1. The [REDACTED] H15 would also have been available. It is noted that according to H17's account, meetings took place with H17's predecessor on two occasions 24 July 2001 and 26 September 2001, but states that SU1 was not raised by either party in those meetings. The Inquiry Team also notes that despite the explicit warning contained in the letter from the [REDACTED] ID3 in August 2001 of the need for a contingency plan to be put in place should an emergency arise for SU1, no steps were taken to provide for any such contingency. The Inquiry Team notes that H17 has stated that there was no indication that there would be any concerns re an emergency arising in respect of SU1. The Inquiry Team also notes an account provided by the [REDACTED] ID3, that in the course of a telephone conversation with H17 on 5 September 2001, H17 undertook to write to the former foster mother (Mrs [REDACTED]) to advise that the residential place for SU1 could not be kept open for her. There is no evidence that this was followed up with Mrs [REDACTED] H17 did however include SU1's name on a list of adults with a learning disability "*for which action is needed immediately*" in a memorandum to the [REDACTED] on 17 October 2001, copied to the [REDACTED]. There was no further reference to SU1 on Health Board files for a further two and a half years.

- 5.7.3. With regard to the period following the appointment of the replacement [REDACTED] the Inquiry Team notes that there is no file reference and no recollection among professionals interviewed by the Inquiry Team, of any interactions, of any nature, between the [REDACTED] (H18)/ [REDACTED] (H17), and SU1 either through Mrs [REDACTED] other Professionals or the Day Services from July 2002 until August 2004. This suggests to the Inquiry Team that there was no adequate system of hand-over and no follow up on the particular circumstances of SU1's placement or the decisions reached previously by the Professionals involved in SU1's care. It should be noted that the deadline of January

2002 set by the Professionals meeting in February 2001, for legal steps, including wardship, to be explored, passed with no action being taken.

5.7.4. Of particular concern to the Inquiry Team is that a further opportunity presented itself in August 2004 for staff to acquaint themselves with the circumstances of the on-going concerns regarding SU1's placement. This arose from the attentiveness of the [REDACTED] of ID3 who wrote to the Health Board inquiring as to whether SU1 should be maintained on the waiting list for residential placement. The response of the [REDACTED] (H18) was to write to Mrs [REDACTED] asking whether she required residential placement for SU1. There was no response from Mrs [REDACTED] no follow up from H18 and no record of a response from H18 to ID3 Residential Service. The Inquiry Team would be of the view that there are three possible scenarios which gave rise to the actions of H18 in this matter. The first is that Mrs. [REDACTED] address was located from the file but that there was no further examination of the file. The second possible scenario is that H18 examined the file and formed the view that the decision as to whether SU1 should remain on the waiting list for residential care should be for Mrs. [REDACTED] to decide. The third potential scenario is that there was no examination of the file and correspondence was issued without having regard to the circumstances of the placement and the historical issues relating to previous attempts to move SU1 to residential care. H18 availed of an additional opportunity to examine the files following the issuing of the Draft Findings by the Inquiry Team in September 2011. H18 then provided an additional written submission. In that submission H18 has suggested that had he read the file and that *"....based on previous assessments (2001), (H18) would have had no grounds to seriously question the circumstances of the placement"*. H18 has also made a number of other points which The Inquiry Team suggests that the HSE give consideration to in examining the findings of this Report. Having fully considered the actions taken in 2004 relating to SU1 and the additional submissions made by H18, the Inquiry Team's view is that whichever of the possible scenarios identified above actually occurred, any one of those scenarios represents a failure to discharge duty of care responsibilities to SU1.

5.7.5. From its examination of the files, the Inquiry Team is satisfied that no home visits took place to the [REDACTED] in 2005 and 2006 and no other interventions or interactions took place on the part of Health Board staff in respect of SU1 during that period. The Inquiry Team also finds that there is no evidence that any actions were taken at that time in respect of the

frequent absences of SU1 from the ID1 Day Services either on the part of the Day Services or on the part of the Health Board.

- 5.7.6. In the course of substantive submissions in response to draft findings, H17 referred the Inquiry Team to the possibility of additional information being available on a Regional Co-ordinator Disability Services file. Following an examination of that file for references to either SU1 or the former foster placement, correspondence was noted from the [REDACTED] to the Department of Health and Children on 23 April 2004. That correspondence records that SU1 was placed in the Residential Service ID3 in 2001. As SU1 continued to reside with the [REDACTED] this information was clearly inaccurate. H17 has stated that such information could not have been provided through H17's office. The Inquiry Team is not in a position to establish the source of the inaccurate information relating to SU1's placement at that time.
- 5.7.7. The Inquiry Team is of the view that the failure to follow up on the decisions of the Professionals meetings, the failure to document/adequately communicate those decisions to the incoming [REDACTED] the failure to adequately inquire into the circumstances surrounding the decision not to avail of a residential placement for SU1 and the failure to respond to the warning from ID3, represented a failure to discharge duty of care obligations, notwithstanding the absence of a liaison Social Worker for a period of twelve months. The Inquiry Team would also be concerned at the lack of any follow up contact with the former Foster Mother in 2001 following her letter to ID3 Residential Service on 28 May 2001 declining the residential placement for SU1 and the failure to adequately follow up on correspondence regarding SU1 remaining on the residential placement waiting list in 2004.

## 6. Preliminary Findings re Key Service Delivery Problems- 2007- 2010

### 6.1. Introduction

6.1.1. July 2007 saw the re-emergence of the SU1 case after an absence of approximately 6 years, with the exception of brief correspondence in 2004. It is noted that the attention of the HSE was drawn to the service user's file through a telephone contact being made by the birth mother (SUR1). This was the first recorded contact made by the birth mother since September 2001. Serious concerns were raised by the [REDACTED] (PD3) to the [REDACTED] (H17) following a preliminary review of the files. H17 advised that if current protection issues were ascertained that these should be dealt with *"in line with the "draft policy for the protection of vulnerable adults"*. In the absence of a national policy for the protection of vulnerable adults, a draft local policy was utilised from October 2007 and adopted on an interim basis in December of that year.

6.1.2. The HSE Area document entitled "Policy and Procedures for the protection of Vulnerable Adults" was stated to provide as follows:

- A policy on managing allegations
- A framework for the investigation of such allegations
- A framework for linking with agencies
- A framework for working with agencies around the investigation of allegations
- The establishment of a "Vulnerable Adults Protection Management Committee".

These guidelines provided both the strategic context and the operational structures within which the protection of Vulnerable Adults should be enacted. The document outlines the role of key positions and functions within an Adult Protection framework. These are chiefly the role of the Designated Person, which is also referred to as Designated Officer in the policy, and the role of the "Vulnerable Adults Protection Management Committee". The Team understands this to be the Vulnerable Adults Committee (VAC). The Team understands that the guidelines were in draft form and were formally signed off at a Vulnerable Adults Meeting (VAC) dated March 2009. The Team notes that prior to that formal sign off, the decision to continue utilising the draft policy

whilst awaiting a national Policy document was agreed at a VAC meeting dated 17.12.07.

6.1.3. The Inquiry Team has noted conflicting accounts from interviewees as to whether the above guidelines were in place operationally or not. The Inquiry Team noted that in interviews with the Inquiry Team PD3, in particular, expressed his view that the policy document would not offer any protection to SU1 and stated that he does not process complaints/concerns in accordance with these guidelines, in the absence of a formal sign off. (The Team notes that PD3 was recorded as being present at the December 2007 VAC meeting where the decision to adopt the policy was taken.) Concern was also expressed by the [REDACTED] (H25), in interview with the Inquiry Team that the guidelines existed only in draft form. During interviews the HSE Management, including the [REDACTED] (H17), stated that the draft guidelines were operational in their area. Ambiguity around the operational status of the draft policy can be identified as contributing to difficulties around decision making and follow up on actions agreed re SU1. This contrast in views among key personnel, in the view of the Inquiry Team, represented a significant ongoing obstacle in responding to the concerns around the placement. The Inquiry Team would also be concerned at the lack of evident attempts to resolve /address any ambiguity around the status of the policy.

Notwithstanding the evident lack of consensus around the exact status of the policy, it is clear to the Inquiry Team that the policy document provided the context within which the service attempted to address and progress the issues arising in relation to the SU1 case from 2007 onwards. (a further analysis of this policy is contained in S. 6.3 below)



6.1.4. Key events identified by the Inquiry Team in respect of this period are set out in section 4 of this Report. The Inquiry Team has categorised the key service delivery problems for the period 2007-2010 under a number of headings having regard to the facts established and best practice policies and guidelines in operation during this period. The principle headings are set out below.

6.2. ***The notification of concerns re SU1 and the management of those concerns in 2007***

6.2.1. The following represents a synopsis of the principal steps undertaken when the SU1 file was examined in August 2007.

6.2.2. Contact by the service user's birth mother with the LHO Social Work Department on 20 July 2007 led to an examination of service user SU1's file by the [REDACTED] (PD3) on 7 August 2007, following his return from leave. Serious concerns were identified by the [REDACTED] from the file, including:

- The lack of any recorded contact on file from May 2001
- The lack of recorded actions taken arising from case conferences in 1996 and Professionals Meetings in 2001 relating to the service user
- Evidence on file of the Health Board receiving allegations of child sexual abuse against the male foster parent (deceased since 2001) in respect of a child (SU3) in the placement.

These concerns were recorded in a file note by the [REDACTED] [REDACTED] PD3 on 15<sup>th</sup> August 2007 and the following recommendations were made:

- i. The case files to be properly ordered and bound
- ii. Checks to be undertaken with previous Social Work and other relevant personnel to continue to fill in the gaps in file
- iii. Assessment of the current situation through a home visit, liaison with Day Services, and determination of availability of residential placement
- iv. An assessment of the current level of the birth mother's willingness to be involved and to offer the birth mother counselling to address her own issues and to help her to become more involved in decisions
- v. Legal advice to be sought to clarify SU1's status and if necessary wardship proceedings to be brought by the HSE.
- vi. Professionals meeting to be called to address current placement issues
- vii. A Care Plan to be drawn up and put into action

6.2.3. The Inquiry Team notes that PD3 e-mailed the [REDACTED] H17 on 21 August 2007 requesting a discussion re SU1, whom he described as a vulnerable adult and indicating that he was conducting a preliminary assessment of her situation. The Inquiry Team understands that H17 e mailed PD3 on 21 August 2007, requesting him to follow up on his recommendations as follows:

- To carry out a full assessment of SU1's placement and complete a report on this
- If ascertained that there were current protection issues, to advise H17 as *"this should be dealt with in line with the draft policy for the protection of vulnerable adults"*
- An urgent meeting would be required to make recommendations re a Protection Plan for SU1 and options for future placements
- If no protection issues identified that a Care Plan may be put in place with the Disability Team in conjunction with current and potential service users.

6.2.4. The Inquiry Team understands H17's e-mail to outline responsibilities/tasks which would be consistent with PD3's role as Designated Person as outlined in the [REDACTED] Job Description. The Inquiry Team would also note that there is no evidence of discussion of, or reference to, H17's correspondence with the residential centre ID3 in 2001 or H17's correspondence and a telephone conversation between H17 and the birth mother on 10 September 2001. PD3 has stated that there was no reference on file to such contacts and was not advised by H17 of those contacts. H17 has stated to the Inquiry Team that while she has no recollection of raising this matter at the Vulnerable Adults Committee, that she did advise PD3 of her contacts with the birth mother when PD3 first raised the case (August 2007).

6.2.5. The Inquiry Team notes that the [REDACTED] (PD3) made contact with health professionals referred to on file throughout August 2007, including H3, H14, H4, and met with the [REDACTED] (SP1) where the service user was last known to have attended. The files examined by the Inquiry Team indicate that, beyond visiting the day placement to discuss SU1 with the [REDACTED] the ID1 case files for the service user were not reviewed by assigned HSE staff at that time. ID1 did provide a report on the service user's attendance record but the subsequent report received covered only the current period from mid 2007. PD3 made telephone contact with the birth mother on 23 August 2007. In the course of that telephone conversation PD3

indicated to the birth mother that she had the right to access SU1's file through the Freedom of Information Act. The Inquiry Team is unclear as to why this was put to the birth mother as a first option rather than through a planned release of information which the birth mother could be assisted in assimilating.

6.2.6. The Inquiry Team notes that a Home Visit was carried out by PD3 and [REDACTED] H21 on 13 September 2007 which raised additional concerns in respect of the lack of clarity around SU1's sleeping arrangements. During interview the Team heard that this visit resulted in the [REDACTED] (H21) describing SU1's "*uncared for*" appearance during that Home Visit in a way which should reasonably have raised specific concerns around neglect: "*.....looked very unkempt, she had poor dental hygiene, her hair was dirty..., she was dressed like an infant ...her entire presentation was inappropriate,*" (Interview with H21 on June 25 2010)

6.2.7. In the documentation examined by the Inquiry Team there are concerns around whether a "full assessment" of SU1's placement, as requested by the [REDACTED] on 21 August 2007, was carried out in a timely manner. Such a full assessment could be expected to have included, for example, information on other individuals reportedly residing in the former foster home, the status of those individuals, and concern around sleeping arrangements for SU1, which do not appear to have been clearly established. This latter issue was the source of some expressed concerns following the Home Visit and was identified as a factor in PD3 concluding that SU1's care arrangements were not at a required standard. Other aspects to be explored in such an assessment may reasonably have included; SU1's likes and dislikes both in home and in the Day Service, details of her weekend and evening activities which would indicate her opportunities, or lack thereof, for social or community inclusion. An assessment may also have included an examination of information about her current health status given that there was evidence, albeit over a relatively short period, of repeated absences from Day Services. Given the stated concerns identified, the Inquiry Team would have expected this assessment of the current situation to be completed and compiled in writing in a timely manner. The Inquiry Team notes the absence of a written report in 2007, although a verbal/flipchart presentation was reportedly provided to the VAC in October 2007, and that the first written report was provided in January 2008, "*for the purposes of obtaining legal advice*". The Inquiry Team is concerned that there was a significant gap between the identification of

concerns regarding the placement (Home Visit August 2007) and the January 2008 Report. The Inquiry Team would acknowledge that throughout September and October 2007 PD3 continued to make contact with health professionals such as the [REDACTED] (H5) and a Garda from the area where the foster placement was located, a General Practitioner from the area, the Office of the Ward of Court, and the LHO Solicitors. However, this activity did not result in a comprehensive written outcome of any assessment undertaken.

- 6.2.8. The Inquiry Team notes that PD3 reported back to the newly formed Vulnerable Adults Committee (VAC) in October and November 2007, and presented verbal assessments with the assistance of flipcharts of his concerns re the placement. The Inquiry Team also notes that the case was categorised as "sexual" in the minutes of the VAC meeting in the absence of any comprehensive assessment of risk to SU1. The Inquiry Team further notes that at the 14<sup>th</sup> November VAC meeting, discussion took place in relation to the holding of a case conference, but that this was opposed by the [REDACTED] (PD3), on the grounds that he was unhappy to proceed without legal advice re information sharing with non HSE staff. The [REDACTED] (PD3) has advised the Inquiry Team that his opposition to the holding of a case conference was based on his concern around the legal status of such a meeting and the disclosure of information at that meeting which could potentially give rise to legal implications for those making such statements. PD3 also stated that he had concluded at that point that the only means available to safeguard the welfare of SU1 was to transfer her to a residential setting and that his understanding was that this could only be achieved through the Ward of Court process.
- 6.2.9. The files examined by the Inquiry Team indicate that in fact there was just one further home visit carried out by the Social Work Service for Disabilities in 2008. There were two other occasions when PD3 and ID1 staff accompanied SU1 to FP's following discharge from A&E in August 2008 and March 2009. These home visits did not result in any clarity around SU1's sleeping arrangements or the number of individuals who may have lived in the [REDACTED] house, despite the stated concerns.
- 6.2.10. Despite the significant activity undertaken following the examination of SU1's file in early August 2007, the Inquiry Team has not identified any tangible protective steps taken by the responsible HSE staff to deal with any concerns relating to the placement identified from the file, from the home visit, or from the interactions with professionals who had experience in

dealing with SU1 and the former foster parent in the past. Despite attempts to hold a case conference, no such case conference was proceeded with. Notwithstanding any concerns that PD3 had around the status of such a case conference, there was a clear obligation to involve HSE staff who either currently or historically had an involvement with the placement. The Inquiry Team would also be of the view that there was an equal obligation to involve representatives of ID1 Day Services, who had the greatest potential professional and personal interaction with SU1 through its Day Services provision and who would be in a position to identify any concerns presenting in respect of neglect or other potential abuse indicators and who would have been in a position to monitor and report on SU1's attendances.

### **6.3. *Role of the Vulnerable Adults Committee in respect of SU1***

- 6.3.1. The Inquiry Team notes that the VAC policy states that the overall purpose of the Committee is to support the role of the Designated Person and that it would meet to:
- Consider all allegations ( of suspected abuse)
  - Make decisions re informing Gardaí/other relevant agencies
  - Appoint a key worker
  - Arrange for the calling of appropriate strategy/case conferences
  - Take an overview of case work, following an allegation
  - Monitor all investigations
- 6.3.2. As referred to in paragraph 6.1.1 above, the policy document entitled "Policy and Procedures for the protection of Vulnerable Adults "was produced by the relevant HSE Local Health Area and provided for the establishment of the Vulnerable Adults Committee (VAC) which, together with the role and function of the Designated Person, forms a core part of the protection framework. The Inquiry Team understands the value of the forum as a mechanism to support the work around the protection of vulnerable adults. The Inquiry Team also understands that there was an identified need to support the Disability Team in that area of work. However within a short period of time, difficulties began to occur with issues emerging

around the validity of decisions reached at VAC meetings. The Inquiry Team notes reports and accounts of divergent views apparent between the [REDACTED] (H17) and [REDACTED] (PD3) in relation to alleged non follow up of decisions reached at VAC.

6.3.3. The Inquiry Team notes that the SU1 case was not formally discussed until the VAC Meeting of November 2007. The files indicate that at this meeting it was decided that a Case Conference would be convened for 12<sup>th</sup> December '07. The Inquiry Team understands that PD3 opposed the holding of this case conference and that the scheduled case conference did not proceed due to PD3's objection. This important meeting was not rescheduled, nor were there any arrangements made through the VAC to hold alternative briefing meetings with the primary service provider (ID1). As a consequence, the sharing of relevant information did not take place. It is the opinion of the Inquiry Team that the failure to hold a case conference can be identified as a key obstacle in delivering an effective response to the care issues identified around SU1.

6.3.4. The Inquiry Team understands that the VAC meeting of 7 December 2007 further discussed the holding of a case conference. The [REDACTED] raised concerns with the Chair of the VAC re information sharing with an external agency (the Day Service providing services to SU1 since 1995) and proposed that, prior to any official meeting with external agencies there was a need to obtain legal advice. The Inquiry Team understands that this objection was raised on the basis of the potential legal risks to those involved in disclosing issues to the Case Conference rather than any evident consideration as to whether the holding of a Case Conference would be in the best interests of SUI. The Inquiry Team would also note that no active consideration appears to have been given to holding a Professionals Meeting as an alternative. The minutes suggest that the Chair of the VAC agreed to proceed to request legal advice. This legal advice was obtained and indicated that more background information was required in order to provide appropriate legal opinion. The [REDACTED] PD3, was asked to provide a report for this purpose. The Inquiry Team considers it unusual that the VAC found it necessary to seek legal advice in this matter as appropriate information sharing with the sole service provider should reasonably have been considered to be in line with best practice. The Inquiry Team is also concerned that this decision contributed to a focus

being placed on a legal framework to deal with the placement rather than a Social Worker/health professional framework of intervention.

6.3.5. The Inquiry Team notes that there was no evidence in the files examined to suggest that either a protection plan or a care plan emerged from the assessment carried out by PD3, by the involvement of any other HSE professional or through the intervention of the Vulnerable Adults Committee. There is evidence of dental treatments, visits to the GP etc but all individualised references on file rather than part of an overall care plan designed specifically to meet SU1's needs. The Inquiry Team noted that there was a distinct absence of a collaborative working relationship between the HSE and ID1, SU1's only service provider. Indeed contact and information sharing with ID1 was less than what could, in the opinion of the Inquiry Team, be reasonably expected.

6.3.6. The draft policy document provides the context within which the protection of Vulnerable Adults should be enacted. It does provide the structures to support an Adult Protection assessment. However the Inquiry Team saw little evidence of this policy being implemented with regard to the protection of SU1. Although there is evidence of contacts being made with a number of health professionals involved with the service user as well as a home visit, there was no evidence of a co-ordinated assessment/investigation of the presenting issues which would then determine what, if any, were the current protection issues. The Inquiry Team found a lack of evidence to indicate what might be described as a Protection/Support Plan for SU1. The only solution being considered was to remove SU1 from the [REDACTED] house, either by mutual agreement or through Ward of Court proceedings. While the Inquiry Team can understand the rationale for these proposed courses of action, it is clear that no other action was considered in terms of reducing risk to SU1, even on an interim basis e.g. increasing monitoring visits to the former foster placement.

6.3.7. The Inquiry Team notes that there is a record of only one planned home visit to [REDACTED] being conducted during 2008 and there is no evidence to indicate that regular monitoring of the placement was carried out. (PD3 also accompanied SU1 home on one other occasion following her discharge from A&E in August 2008.)

6.3.8. On more than one occasion during this period of time, the [REDACTED] voiced her concerns regarding what

she perceived as a lack of action by the [REDACTED] (PD3) in following up decisions taken at VAC and in relation to progressing matters in this case. On the other hand, PD3 expressed frustration at what he perceived as failure to take immediate steps to make application for Ward of Court and to remove SU1 from the placement, which PD3 viewed as the only recourse to ensure the protection of SU1. The files also indicate a level of frustration on the part of the Chair of the VAC in respect of alleged failure by PD3 to follow up decisions of the VAC. The [REDACTED] is on record as stating that *"a lack of a legal framework is no reason for inaction. We must all act in the clients best interests"*. This disparity of opinion regarding decisions of the VAC not being followed was ongoing throughout the period under review. The Inquiry Team notes the repeated insistence of the [REDACTED] (PD3) to postpone taking any alternative action in this case other than to await legal advice, a position which led to conflict with the VAC and particularly with the [REDACTED] H17. It is the view of the Inquiry Team that there was a failure by management to address this ongoing staff issue and this remained a feature of this case throughout. This suggests to the Inquiry Team a lack of overall effective management in this case and further suggests issues of individual professional accountability which need to be addressed.

6.3.9. The Inquiry Team notes that when crucial decisions had to be taken around the consideration of legal advice and representations made by both the birth mother and the former foster parent in early July 2009 on the removal of SU1 to the ID1 residential placement, no apparent consideration was given to having these issues discussed at a VAC meeting.

6.3.10. The Inquiry Team has formed the view that the VAC did not function as the accountable forum to deal with the emerging issues. It would also appear that this issue of the status of decisions reached at the VAC was not dealt with successfully at any level. Specifically, in relation to SU1 the Inquiry Team is of the view that the VAC failed in its stated duty to monitor an investigation into the immediate concerns relating to SU1's care. The Inquiry Team would have expected that an investigation into the areas of concern relating to SU1's care would have included the gathering of factual information, taking care to distinguish between fact, allegations, concerns and opinions and assess the level of risk, if any, to which SU1 was exposed. The outcome of such an investigation in turn should inform the Protection/Support plan to be put in place for SU1 if so required which would have been facilitated through the holding of a Case Conference. The Inquiry Team notes that



the convening of a case conference in such circumstances is clearly set out in the Vulnerable Adults policy. On the basis of the information examined by the Inquiry Team it is our view that there was a lack of clarity in respect of the status of decisions made at the VAC and the accountability of the [REDACTED] [REDACTED] to the VAC in respect of the implementation of those decisions. The Inquiry team further finds, that there is no evidence of a social work line management intervention, up to the time of the appointment of the [REDACTED] in mid - 2008, in respect of the claimed failure by the [REDACTED] (PD3) to implement those decisions. Following the appointment of the [REDACTED] the Inquiry Team would note that attempts were made to address these performance issues but ultimately these issues remained unresolved. In summary it is the Inquiry Teams view that the failure to act on decisions of the VAC, the failure of VAC to resolve this significant issue and the apparent inability of the wider HSE management structure to address the issue, significantly compromised the effectiveness of the adult protection process re SU1

#### **6.4. *The measures taken following the notification of injuries to SU1 notified in 2008 and March 2009***

6.4.1. Prior to the attendance by SU1 at A + E on 20 August 2008, the Inquiry Team notes that PD3 was notified by ID1 on 20 June 2008 of concerns around several scratches on SU1`s lower back. These marks and other reports of bruising in May, June and July 2008 were also brought to the attention of H17 by PD1 on 21 July 2008, immediately prior to a meeting arranged with MRs [REDACTED] 1. PD3 reported the marks notified on 20<sup>th</sup> June 2008 as "possible friction burns" Although these matters were followed up by ID1 to the extent that Mrs [REDACTED] was questioned, this was done in the absence of any additional information from the HSE around concerns re the placement.

6.4.2. On 20 August 2008 ID1 staff reported bruising and broken skin around SU1`s eye area as well as an older injury to the finger of one hand. This injury was referred to PD3 and SU1 was brought to A+E. The Inquiry Team notes that there is no evidence of an assessment around the bruising sustained by SU1 in August 2008. The files contain references to SU1 hitting her head whilst on the bus but the files do not suggest that this was ever followed up by the HSE in accordance with the draft Vulnerable Adults policy. An approach was made by H17 on September 1 to PD3 to follow up with SU1`s GP and the relevant [REDACTED] In addition, a request was made to PD3 to

formally request a weekly report from ID1 on SU1's physical condition. There is no record available to the Inquiry Team that this request was communicated to the service provider (ID1).

6.4.3. The Inquiry Team notes that at the VAC meeting of 26<sup>th</sup> August 2008, the [REDACTED] states that SU1 continued to present as being "unkempt, teeth and hair poor". The Inquiry Team did not see any evidence in the documentation reviewed that this concern, which could be construed as indicating neglect, was actively followed up. The Inquiry Team notes that the requests made by H17 on September 1 2008 to undertake the follow up steps resulted in PD3 disputing the scope of the request and stating that he could no longer work on the case "under the current circumstances".

6.4.4. In March 2009, staff at ID1 discovered suspicious bruising on SU1's thigh and breast. In consultation with PD3, the Gardaí were contacted and advised that SU1 be taken to A&E. It was on the advice of A&E that SU1 was referred to the Sexual Assault Treatment Unit (SATU). The Inquiry Team understands that following the examination by SATU a decision had to be taken as to whether to return SU1 to the placement or to arrange temporary accommodation. The Inquiry Team further notes that there were differing accounts between PD1, PD2, and PD3, who were all present at the accident and emergency department that night, of the options available. PD1 and PD2 state that they can clearly recall that they informed PD3 that there was a respite place available in their service that evening. The [REDACTED] ID1 Day Services has also advised that she was in attendance at the hospital and is clear that a respite bed was offered to the [REDACTED] (PD3) as an alternative to SU1 returning to the former foster placement. PD3 asserts that he was not aware of this as an option.

6.4.5. The Inquiry Team understands from evidence from one of the disclosers that the SATU assessment indicated that there was no evidence of a sexual assault. Notwithstanding this, the Inquiry Team appreciates that the professionals involved, in ID1 and HSE were faced with a difficult decision as to whether to return SUI to the placement and that this difficulty was further exacerbated by the lack of common understanding between those professionals as to what other options were available. The Inquiry Team notes that the ultimate decision rested with the [REDACTED] PD3 and that while the decision to return SU1 to the placement may have been in accordance with the accepted

legal position, the Inquiry Team would be of the view that this decision was not necessarily in the best interests of SU1.

**6.5.      *The removal of SU1 from the former foster placement***

6.5.1.      The Inquiry Team has examined the process and rationale associated with the removal of SU1 from the former foster placement to residential care in ID1, having regard to the following:

- The background of a series of injuries being reported by Day Services Staff
- The involvement of the Vulnerable Adults Committee
- The level of consultation between the HSE and ID1
- The level of consultation with the Birth Mother
- The level of involvement of PD3
- The securing of legal advice
- The decision taken to remove SU1

6.5.2.      With regard to the reporting of Day Service recorded injuries and absences, the Inquiry Team would note that the following injuries to SU1 were recorded by Day Services Staff in 2008/2009 following the introduction of a formal system of recording injuries to service users on presentation for Day Services:

- 22/02/2008      Left eye bruised
- 09/05/2008      Broken skin on base of back
- 10/06/2008      Four separate red marks on the spine
- 20/06/2008      Three scratches on her back
- 01/07/2008      Red marks on lower back
- 20/08/2008      Bruising and broken skin around eye area as well as an old injury in one finger
- 27/03/2009      Bruising on thigh and breast

6.5.3.      From the files available to the Inquiry Team, there is no evidence that either the HSE or Day Services jointly or separately conducted thorough assessments in respect of the above injuries once recorded. PD1 has indicated that she was advised on taking up post, that any injuries or concerns relating to SU1 would be referred to the [REDACTED] prior to any preliminary screening by ID1. The ID1 Day Services Manager has also stated that marks to SU1's body were discussed with Mrs [REDACTED] (in June/July 2008) and that she spoke to the day service bus driver in August 2008 about the possibility of an eye injury being caused by SU1 banging her

head on the bus window. The Inquiry Team would also note that although the [REDACTED] was aware of some of the above injuries as they arose, the full extent of the above injuries did not become known to him until he examined SU1's case notes in ID1 Day Services on 27 March 2009, reportedly at the suggestion of PD1. The list of injuries as summarised in 6.5.2 above was, according to PD1, made available to H17 on 21 July 2008. The Inquiry Team finds it difficult to understand why those case notes were not sought or examined by the responsible HSE staff at the outset. Such examination would have facilitated planning around protective measures and also would have ensured that such detail was accounted for in the documentation prepared by the [REDACTED] for the VAC and for the purposes of obtaining legal advice. The Inquiry Team acknowledges that the [REDACTED] on September 1<sup>st</sup> 2008 asked the [REDACTED] to formally request ID1 Day Services to monitor SU1 following the incident and report back weekly on SU1's physical condition.

6.5.4. In examining the rationale for the HSE finally removing SU1 from the placement in July 2009, the Inquiry Team has not identified a direct link between that decision and the reported instances of injury to SU1 as reported in 2008 and 2009. The Inquiry Team would note however that the birth mother, when contacted by H17 on 2 July 2009 advised H17 that on the basis of the reports to her by PD3 of bruising sustained by SU1, she was requesting that SU1 be moved from the foster placement.

6.5.5. With regard to the role played by the Vulnerable Adults Committee in the removal of SU1 in July 2009 from the former foster placement, the Inquiry Team has detailed its overall concerns in section 6.3 above regarding the effectiveness of that committee. The Inquiry Team notes that the last recorded meeting of the VAC prior to the removal of SU1, was on April 27 2009. At that point the VAC was "awaiting advice from Senior Counsel and [REDACTED]". The Inquiry Team understands that the decision to remove SU1 from the placement, and the rationale for that decision, was not discussed within the VAC following that date. (There is no evidence that attempts were made to call a VAC meeting at that time). Accordingly the Inquiry Team understands that no consideration was given by the VAC to the following emerging issues:

- The communication of specific information around the "fingertip bruising" to breast and thigh sustained by SU1 in March 2009, by PD3 in a phone call to SU1's mother in July 2009 and his recommendation that she would write to HSE requesting that SU1 be moved. (The Inquiry Team is

aware that the bruising was reported at the VAC meeting of March 2009. There are no actions minuted re this concern)

- Receipt of the verbal report of Senior Counsel advice of 8 July 2009.
- The request from the birth mother to move her daughter on 2 July 2009
- The decision to move SU1 on 24 July 2009
- The decision to vary the removal date to 17 July 2009 based on a conversation between H17 and Mrs FP and a subsequent conversation between H17 and the birth mother on 16 July 2009.

6.5.6. The Inquiry Team notes that PD3 was on annual leave at the time of the receipt of Senior Counsel verbal opinion in July 2009 and the decision taken by HSE Management to remove SU1 from the former foster placement and to vary that date of removal. The Inquiry Team's view is that the actions of the HSE in removing SU1 from the placement with the consent of the birth mother, suggests that this was an option open to them to exercise at any point and particularly from receipt of written consent from SU1's birth mother in April 2008. The Inquiry Team's understanding of some of the rationale for not removing SU1 before that date was that there were disputed courses of action proposed and that the [REDACTED] would not implement decisions of the VAC which were at odds with his advocacy of a Ward of Court application re SU1. The Inquiry Team would note however that the decision to remove could have proceeded (and did proceed) without the involvement of the [REDACTED]. The Inquiry Team recognises that there was a perception that the [REDACTED] perceived lack of co-operation was an obstacle to reaching a resolution in the best interests of SU1. Ultimately however that lack of co-operation with certain decisions of the VAC, while generating significant difficulties for all parties, should not reasonably have proved an obstacle/delay to achieving the objective of a removal of SUI to a more appropriate residential environment.

6.5.7. With regard to the level of consultation between the HSE and ID1, the Inquiry Team notes that a decision of a VAC Meeting dated 29<sup>th</sup> May 2008 states that information available to the HSE re SU1 was to be shared with ID1. There is no evidence of information regarding any concerns relating to SU1

or the placement being shared with ID1 by the person identified in the minutes of the May VAC meeting (H17), to carry out this action. The files show that a meeting occurred between the [REDACTED] and ID1 on 3rd July 2008 re the offer of a placement. However the minutes available on file do not contain any reference to concerns being shared. In her submissions to the Inquiry Team, H17 has stated that she spoke to the [REDACTED] (PD2) on a regular basis and shared information that would not always have been recorded. H17 added that prior to the admission of SU1 into residential care in July 2009, H17 stated that she considered that PD2 "... *was in no doubt with regard to the nature and extent of our concerns re (SU1)*". The Inquiry Team accepts that some information was provided by H17 to PD3, for example to identify a possible placement as early as December 2007. It may also have been the case that assumptions were made by HSE staff as to the knowledge of the concerns around SU1. Notwithstanding any ambiguity around the detail of information provided, the Inquiry Team is concerned that the specific request by the VAC to provide information to ID3 does not appear to have been complied with. On balance therefore, it would appear that ID1 remained unclear as to the exact nature of the HSE concerns in relation to SU1 which informed the decision to remove the service user.

- 6.5.8. With regard to the level of consultation with the former foster mother immediately prior to the removal of SU1, the Inquiry Team notes that an agreed approach was made by H17 and PD3 to FP on 18 February 2009 advising that SU1 would be transferred to a residential placement on a date to be advised. PD1 has advised the Inquiry Team that neither she nor ID1 were aware of those discussions nor were made aware of a recommendation from a Psychologist of a proposed introduction of respite care. Mrs [REDACTED] was advised that the transfer would either be voluntary or would be achieved through Ward of Court proceedings. The next recorded approach to Mrs [REDACTED] was through a letter dated 14 July 2009 from H17 notifying her that SU1 was to be prepared for transfer to residential placement in ID1 on 24 July 2009. Mrs [REDACTED] responded to that notification by requesting that she be allowed to keep SU1 for a further two weeks to take her on holidays. H17 formed the view that there would be concerns re access by the HSE to SU1 if the holiday was to proceed and following consultation with SUR1 a decision was made to transfer SU1 from her day placement in ID1 directly to residential services on 17 July 2009 without notice being provided to Mrs. [REDACTED] of this change to the transfer date. While the Inquiry Team recognises that decisions based on the assessed risk to a service user are open to adjustment in the

best interests of the Service User, the question arises as to whether adequate consideration was given to the potential effects such a pre-emptive transfer would have on SU1. The Inquiry Team notes that a report from a Psychologist on file dated 31 October 2008 recommended the use of respite care as a transition to residential placement for SU1 and did not envisage this being a difficult transition. The Inquiry Team also notes the lack of evidence of any transition plan related to the proposed transfer or any involvement of the VAC in this matter. The Inquiry Team has also had regard to the persistent objections on the part of Mrs [REDACTED] to the removal of SU1 from her care and at this remove accepts that H17 made the decision to remove SU1 before the notified transfer date, in good faith.

6.5.9. With regard to the level of consultation with the birth mother the Inquiry Team notes the following contacts:

- 20.07.07: The birth mother (SUR1) contacts Learning Disability Service to ask for update on her daughter. This leads to the Learning Disability Service revisiting SU1's file
- 23.08.07: Phone call to SUR1 from [REDACTED] (PD3). SUR1 said that she did not want to become involved again as she would not want to go against the former foster parents wishes. She is reported to have said that she had not seen SU1 for 24 years. PD3 informs SUR1 that she could access her daughter's file under FOI
- 23.04.08: [REDACTED] (H17) phoned SUR1 and explained proposed new placement with ID1. SUR1 was reportedly happy with this. SUR1 asked if she could visit and agreed to provide consent for all assessments. SUR1 allegedly stated that she did not like PD3's tone when he contacted her in August 2007 and did not want to deal with him again. SUR1 reportedly said that she was upset by the interaction
- 24.04.08: Letter from H17 to SUR1 stating that she is happy that SUR1 has agreed to residential placement with ID1 and sending on letter re consent for medical and other multidisciplinary assessments. This letter of consent was signed by SUR1 on 30.04.08
- 18.06.08: Letter from PD3 to SUR1 inviting her to discuss SU1's care and advising that the former foster parents will strongly oppose any attempts by the HSE to remove SU1 from the placement. He also suggests that she make an FOI

application to obtain files regarding her daughter from the HSE and provides her with documentation to process this

- 20.08.08: PD3 receives correspondence from FOI Office indicating that SUR1 has sent back completed form
- 03.09.08: H17 informs SUR1 that her daughter had sustained some bruising but that it was not clear how this had occurred
- 21.01.09: The [REDACTED] confirms that he contacted SUR1 in December and informed her that they were intending to initiate Ward of Court proceedings if Mrs. [REDACTED] did not agree with SU1 being moved. SUR1 indicated her approval of same. SUR1 was also asked to attend a meeting but declined same
- July 2009: PD3 reportedly informs SUR1 that the bruising sustained by her daughter and referred to by [REDACTED] may not be accidental
- 2.07.09: H17 returns call to SUR1 who tells her that she has been informed of the bruising by the [REDACTED] and that she wanted SU1 moved from the former foster placement. They agree to meet when SUR1 comes to Ireland. She tells [REDACTED] of her distress re the recent information she has received
- 13.07.09: H17 meets with SUR1 in Ireland. SUR1 states that she wants SU1 "moved immediately" and puts that request in writing
- 17.07.09: SUR1 contacted again re immediacy of move. SUR1 reaffirms her request that she is moved "today"
- 27.08.09: Phone call from [REDACTED] ID1 to SUR1. SUR1 stated that she was not aware that the HSE had any concerns in relation to her daughter until July 09 (Phone Call from [REDACTED])

6.5.10. The Inquiry Team notes that the birth mother's consent to have her daughter moved to the ID1 residential placement was obtained by the HSE on 30 April 2008. Agreement was also reportedly obtained from the birth mother in January 2009 that Ward of Court proceedings be initiated. The Inquiry Team further notes that no action was taken by the HSE on receipt of such consents other than to approach the former foster parent



for agreement to move SU1. An additional written consent was obtained in July 2009 and on the basis of that consent and on the basis of a report of verbal legal advice, SU1 was removed. The Inquiry Team is at a loss to understand why the action taken to remove SUR1 in July 2009 could not have been put into effect from May 2008. The Inquiry Team would note an apparent inconsistency in the value placed on the consent of the birth mother in justifying or supporting a decision to remove SU1 from the former foster placement. It is not clear to the Inquiry Team as to the qualitative difference between the consents provided in April 2008 and July 2009. It is clear that there ought to have been a greater level of urgency following the August 2008 and March 2009 injuries to SU1 which resulted in hospital examinations, but this does not appear to the Inquiry Team to have translated into practical protective measures for SU1.

- 6.5.11. With regard to the level of involvement by PD3 in the removal of SU1 from the former foster placement, the Inquiry Team notes that PD3 was not directly involved in the decision to remove SU1 in July 2009 as at that time PD3 was on leave. That decision was principally dealt with by H17.
- 6.5.12. With regard to the removal of SU1 from the former foster home, the Inquiry Team notes that ID1 had planned for the admission of SU1 to its Residential Services on 24 July 2009. For a number of stated reasons which are detailed in paragraphs 5.11.32 and 33 above, the move was brought forward to 17 July with notice that morning to ID1. Despite the lack of notice, ID1 facilitated the transfer and SU1 was moved from Day Services directly into Residential Services that day. The Inquiry Team notes that some preparatory work was carried by ID1 to prepare for the transfer but there was no evidence of coordinated planning between ID1 and LHO1 for the transfer. The Inquiry Team is aware that while preparatory work was carried out by ID1 in anticipation of the scheduled transfer date, there is no evidence of a comprehensive co-ordinated transition plan between the LHO and ID1. ID1 had taken some steps in anticipation of a planned move, but these did not materialise due to the move being brought forward.

**6.6. Other historical issues of concern relevant to SU1's placement**

6.6.1. The Inquiry Team examined the files relating to historical concerns of alleged abuse referenced in the draft response prepared by the [REDACTED] for the purposes of the HSE obtaining legal advice in January 2008 and April 2009 in relation to SU1. These issues were examined to establish if the professionals involved in managing SU1's placement had knowledge of these issues and whether such concerns were appropriately assessed to determine the suitability of the placement for SU1. The full detail available to the Inquiry Team of the assertions/suspensions of possible abusive interactions relating to other service users is not detailed below. Such detail, as understood by the Inquiry Team, has been separately furnished to the HSE by way of a letter dated 27 September 2011.

**SU3**

6.6.2. The Inquiry Team understands that following his examination of the SU1 file in August 2007, PD3 identified from the file that there had been previous concerns regarding the placement, identified by the parent (SUR3) of another service user, (SU3). The Inquiry Team further understands that PD3 made telephone contact with SUR3 and identified SUR3 as the parent of the service user who had reported the concerns to the LHO area regarding the [REDACTED] placement in the early 1990's. The Inquiry Team understands that in the course of PD3's telephone conversation with SUR3 in August 2007, the parent gave an account of issues raised with the then Health Board, HB3, regarding the temporary placement of the service user with the [REDACTED] in late 1990. PD3 took a note of that conversation and reported serious concerns to the [REDACTED] and the newly formed VAC. The account of that conversation, which detailed serious concerns including the handling by the then Health Board of placement issues in the early 1990's, was included in reports provided by the [REDACTED] to the VAC and for the purposes of the HSE obtaining legal advice re the continuation of SU1's placement.

6.6.3. The Inquiry Team is unclear if PD3's note of August 2007 telephone conversation was checked for accuracy with SUR3. The Inquiry Team understands that the next recorded

contact between PD3 and SUR3 was some two years after the initial contact.

- 6.6.4. The Inquiry Team notes that the account provided by SUR3 by telephone to PD3, featured in reports provided to the VAC and to LHO1 Solicitors.
- 6.6.5. The Inquiry Team understands that PD3 did not notify the [REDACTED] before contacting and meeting with SUR3 in late 2009. The Inquiry Team would also note that a report on the 2009 contact with SUR3 was circulated in early 2010 to HSE Management and to the Inquiry Team as part of an updated report by PD3, and contained substantive clarifications and amendments to the original report by PD3 in early 2008.
- 6.6.6. The Inquiry Team notes the apparent lack of a structured approach toward establishing and documenting the facts around the concerns raised by the service user's parent regarding the service user's reported experience of the placement, the Health Board process in addressing concerns in the early 1990's and an exploration of the reported medical evidence supporting serious allegations of abuse.
- 6.6.7. The Inquiry Team notes from the file that in the course of a home visit by a [REDACTED] on March 28 2007, SUR3 disclosed accounts which contained the contention that the service user had been the subject of abuse and had alleged that this was linked to a historic placement with the [REDACTED]. The Social Work file note on March 2007 indicated that SUR3 did not wish to have the case re-opened. The Inquiry Team have recommended, as referred to in paragraph 6.6.1 above, that the HSE separately establish the facts around any such reports.

## SU2

- 6.6.8. The Inquiry Team understands that PD3 became aware in August 2007 of complaints regarding the [REDACTED] placement made by the parent of another service user SU2 to the Health Board (via a foreign Health Authority) in 1996. The Inquiry Team understands that PD3 then made contact with An Garda Síochána in September 2007 re SU2, and was advised shortly thereafter that no investigation of the SU2 complaints had taken place (in 1996) reportedly in the absence of a formal complaint being made. There is no record on file of direct contact being made by the [REDACTED] or by the VAC with SU2's parent (SUR2).

6.6.9. The Inquiry Team has made a number of observations in respect of the actions of Health Board personnel in 1996 when the alleged abuse was notified (see paragraph 5.4.3 above). The view of the Inquiry Team is that the HSE should examine whether there was a failure of the then Health Board to investigate a written complaint by SUR2 in respect of the service user (SU2) in accordance with the Child Protection Policy in place in the Health Board area at that time. This complaint arose from a period when SU2 was placed with the FPs. The Inquiry Team has recommended that the HSE examines whether the duty of the HB3 to investigate the claims to the extent that was possible in the circumstances, was appropriately discharged.

#### **SU4**

6.6.10. The Inquiry Team understands that service user SU4 was placed with the [REDACTED] for a short period in the late 1980's. The Inquiry Team also understands that SU4 presented to a hospital in the mid-2000s with clinical indications which may have related to a number of factors including concerns around possible abuse. The Inquiry Team is unaware of any substantive investigation or assessment being carried out to determine whether there was any link between the presentation at hospital and the placement with the [REDACTED] some sixteen years previously. Accordingly, the Inquiry Team queries why these details were subsequently furnished, without any evident comprehensive Social Work assessment, in a report from PD3 to the VAC and LA2 Solicitors under the heading "sexual abuse". The Inquiry Team is further of the view that the inclusion of this issue served to raise legitimate questions about the objectivity of the draft report prepared by the [REDACTED] PD3.

## **SU5**

6.6.11. The Inquiry Team understands that in March 2009, the parent of an ID1 Day Service user indicated to ID1 staff that the parent did not wish to have the service user avail of respite care again. The parent further reported that the service user (SU5) had been on respite in the [REDACTED] and the service user SU5 had complained to the parent about specific alleged physical mistreatment. The Inquiry Team understands that PD3 interviewed SU5 and an immediate family member in mid 2009 and concluded that the disclosure made by SU5, regarding what PD3 considered physical abuse in the placement, was credible. The Inquiry Team understands that the allegation related to a period when Mr. [REDACTED] was still alive (pre 2000). The Inquiry Team also understands that PD3 issued a report regarding SU5 to the [REDACTED]. The Inquiry Team is unaware of any recorded follow up of this disclosure by the HSE and recommends that the HSE would establish the facts around these reports.

6.6.12. The Inquiry Team understands that in November 2009 the [REDACTED] (H26) established a working group to look at historical issues highlighted relating to concerns by service users on placement with the FPs.

## **6.7. *The role of ID1 Day Services and ID1 Liaison with the HSE***

6.7.1. SU1 commenced a day placement in ID1 Day Services in 1995 and remains there to date. Although there was provision for a full time placement, initially SU1 attended on a part time basis and this only extended to a 5 day attendance in July 2008. There are limited case notes available for SU1's earlier time in the Day Service but a report prepared by the then [REDACTED] SP1 some months after SU1's admission depicts a vivid picture of SU1's initial presentation which was described as "chaotic"; It has been reported that the Service had a favourable impression of Mrs. [REDACTED] as several other service users availed of respite placements there. It was also reported that the [REDACTED] considered that SU1 was fortunate to have a HSE Social Worker assigned to her case. SU1's attendance over the years has been characterised by frequent periods of absences, some quite lengthy. The documentation of attendance seen by the Inquiry Team indicates that SU1 only attended for a small number of days per month until, what the Team understand to be the intervention

of the newly appointed [REDACTED] (SP2) in March 2008. The Team read that ID1 sometimes queried the absences by phone with Mrs. [REDACTED] but there is no indication on file that these frequent absences were deemed to be of sufficient concern to merit reporting to the HSE through the then [REDACTED]. The Team understands that staff and management in ID1 were aware of the frequent absences of SU1 and there appeared to be some unofficial understanding that SU1 availed of services approximately 2 days per week.

6.7.2. When PD3 met with the then [REDACTED] (SP1) in August 2007, it is noted that SP1 advised of frequent absences of SU1 from Day Services and subsequently provided information relating to the most recent absences. The Inquiry Team notes that at the time of the referral of unexplained injuries to the Gardaí in March 2009, it is reported that PD3's attention was drawn to SU1's file by PD1 and examined same. As a result of which a report "*in regard to incidents and non-attendances*" was requested from ID1. A draft version of that report was received in July 2009 with the final report submitted by PD1 in August 2009.

6.7.3. In 2008, following the appointment of a new [REDACTED] and [REDACTED] the Inquiry Team understands that the practice of completing body charts of suspected injuries/bruising was introduced in ID1 service. The Inquiry Team was advised of records of approximately 20 occasions when the Service completed Body Charts depicting diagrammatically the nature and site of the marks/bruising found on SU1's body. It was reported to the Inquiry Team that on a number of occasions over the years Mrs. [REDACTED] was asked about the bruising and reportedly responded with explanations that the service deemed to be plausible. There is no evidence on file of preliminary screenings or investigations being carried out to determine whether the injuries could have been as a result of an abusive interaction or an accident. The Team notes that in June 2008 ID1 did report "several red scratches on mid and lower back" to PD3. The Team also notes that PD1 advised that a summary of marks/bruises found re SU1 was furnished to H17 in July 2008. There are also references contained in the documentation seen by the Team to SU1 "banging her head on the bus".

6.7.4. It has been stated to the Inquiry Team that PD1 had concerns about SU1's "presentation-personal and oral hygiene, clothing and the condition of her hair" upon her first introduction to SU1 in 2008. Day Service notes also refer to poor personal hygiene as an ongoing feature. ID1 Day Service

reported that, while they were aware that the HSE had plans to find another residential placement for SU1, they were not aware that the HSE had any concerns about her care in the former foster placement until August 2007. It should be noted that the [REDACTED] (SP1) did attend a professionals' meeting, convened by the HSE [REDACTED] in 2001 at which the appropriateness of the placement was discussed. The Team understands that from 2008 ID1's view of SU1 placement was that the HSE had concerns about the continuation of the placement and that they were actively working on moving her from Mrs. [REDACTED] home. A meeting of 3<sup>rd</sup> July 2008 confirmed this with the HSE requesting ID1 to continue to keep a residential place for SU1.

- 6.7.5. The Team notes that PD1 prepared a summary report for H17 of attendances and marks/bruising documented re SU1 on 21 July 2008. A more complete report on information around patterns of attendances, including a history of urinary incontinence, was furnished on 18 August 2009 to the HSE. The Team understands this to be in keeping with PD1's understanding of her role in providing relevant information to the HSE. However the Team would have expected that this information would have been requested and actively sought after as part of the assessment of SU1's situation in 2007 when the case re emerged. The Inquiry Teams finding under this heading is that the fact that this pivotal information was not sourced in a timely manner, contributed to a potential failure to discharge duty of care obligations to SU1 in respect of an investigation into suspected neglect issues.
- 6.7.6. In August 2008 ID1 service alerted the HSE (PD3) of bruising noted to SU1's eye and PD1 liaised appropriately with the HSE on that occasion, including accompanying PD3 on returning SU1 home following a visit to A&E. It is noted that whilst some information was shared with ID1 on this occasion, it is the Inquiry Team's understanding that full disclosure of the concerns did not occur. ID1's main liaison with the HSE in relation to the progress of the SU1 case at this point would seem to have been between PD1 and PD3. On the basis of the information available to the Inquiry Team, the contacts appear to have been centred around the progress or otherwise of the legal position around removing/transferring SU1 from the former foster placement to residential care. The Inquiry Team is satisfied that there is no evidence to indicate that ID1 was made formally aware of the HSE's concerns for SU1 in the placement. The Inquiry Team further finds that although a decision was taken at the VAC meeting dated 28<sup>th</sup> May 2008 to

convey such information to ID1 this was not carried out by the person assigned to convey his information by the VAC Meeting (H17). This placed ID1 at a disadvantage in effectively monitoring SU1 given that it was the sole service provider with reporting arrangements to the HSE. The Inquiry Teams finds under this heading that the failure to inform ID1 of the concerns represented a potential breach of duty on the part of the HSE both in respect of its obligations to ID1 and to the service user SU1. The Inquiry Team would also be of the view that, apart from the HSE's corporate obligations in this matter, the individual staff charged with conveying the concerns to ID1 may not have adequately discharged their duties in this instance. The Inquiry Team cannot identify, on the basis of the information available to date, any justifiable reason for not sharing the detail of the available information re SU1 with the Day Services and proposed Residential Care provider (ID1).

6.7.7. On March 27 2009, following ID1 alerting HSE about bruising noted to SU1's thigh and breast, PD1 accompanied PD3 to A&E. An Garda Siochana and the Sexual Assault Treatment Unit (SATU) were also involved in this. The Inquiry Team finds that there is a variance between ID1's recollection that a respite bed was available in their service for SU1 that night and PD3's recollection that he was not aware of this as an option. Based on the information available, the Inquiry Team would find that ID1 acted appropriately in respect in taking reasonable and practical steps open to it to source a respite option for SU1. It is a matter of regret that this possible option does not appear to have been commonly understood by the professionals involved on that night.

6.7.8. The Inquiry Team understands that there was an increased level of contact between PD1 and PD3 following the March 27 2009 referral. ID1 understood that a decision would be made at the forthcoming VAC meeting and, in anticipation of a decision to remove SU1 from Mrs [REDACTED] home, ID1 met to prepare a care plan for SU1 to assist in her transition to residential care. PD3 later informed PD1 that the outcome of this meeting was to "seek legal advice"

6.7.9. On the 3 July 2009 SU1's person centred planning meeting was held in ID1. (It is unclear if there were HSE personnel present or invited.) Prior to this meeting, PD1 informed PD3 of her intention to raise concerns that ID1 had in relation to quality of life issues for the service user (SU1). It is reported that ID1 felt the need to address this with Mrs. [REDACTED] in



the absence of any confirmation of the proposed move being imminent. The Inquiry Team is not aware of the outcome of these discussions around those concerns but it is noted that the meeting was adjourned after two hours with a further date to be rescheduled. The Inquiry Team is satisfied that the above was an attempt by ID1 to address immediate support issues for SU1.

6.7.10. On 17<sup>th</sup> July 2009 SU1 moved to full time residential care, a week before the scheduled move. The Inquiry Team notes that ID1 asked PD3 for a report on SU1 to inform care planning and PD3 suggests that she puts this request in writing. After several requests this report was finally furnished to ID1 in November 2009, with the proviso that *"some aspects of (SU1's) background that could be relevant to her care plan have been excluded from (the) report for legal reasons"*. The Inquiry Team would reiterate its concern that, even after the transfer of SU1 to residential care, there was a significant delay in providing the appropriate level of information to facilitate care planning and the monitoring of the Service User. Having examined the November 2009 Report the Inquiry Team is at a loss to understand why this information could not have been shared with the sole service provider at least from June/July 2008, particularly where the VAC had made a decision to do so. The view of the Inquiry Team is that the failure to adequately inform the ID1 service provider of the relevant details relating to the concerns for the historic and current welfare concerns for SU1, represented a potential failure to discharge duty of care responsibilities by the HSE Local Health Office and a failure to meet the standard of information sharing that could be reasonably expected where an agency is preparing for the acceptance of a residential referral.

## **6.8. *Legal obstacles to actions being taken to protect SU1***

6.8.1. The Inquiry Team notes that in the period August 2007 until March 2010 there was frequent discussion among health professionals of legal advice being sought and legal recourse being explored to deal with the concerns around the placement. The incidents of interactions between health professionals and legal advisors are set out in the paragraphs below. The Inquiry Team accepts that the legal status of the service user (SU1) was unclear from age 18 onwards. What is clear however is that she continued to be on a voluntary placement with the foster parents and that the Health Board had decided in late

1996 to continue that placement with an agreed monitoring of that placement by social work staff in particular. The Inquiry Team is satisfied therefore that the then Health Board, and ultimately the HSE, continued to have a duty of care to SU1 and that included taking whatever protective measures were necessary and appropriate, including the transfer of SU1 to residential placement. The Inquiry Team would be of the view that the absence of any regulatory measures for such vulnerable adults was a contributory factor to the significant reliance by health professionals on legal advice and the reluctance to take action, including protective measures, in the absence of clear legal advice. The following summary of interactions, related to the obtaining of legal advice, provides a clear indication of how those issues appeared to dominate the approach to addressing the issues of concern regarding the placement. The Inquiry Team wishes to acknowledge the full co-operation of HSE Solicitors (LA2) with the inquiry process and wishes to confirm for the record it's understanding that actions taken/ advice provided to LHO1 was on the basis of the information made available by the relevant officers of LHO1.

6.8.2. The Inquiry Team understands that PD3 e-mailed the Chair of the VAC on 20 November 2007 and proposed that prior to any official meeting with regard to vulnerable adults that included external agencies that they meet with the HSE legal advisors to highlight the issues and to obtain written legal advice. The Inquiry Team also notes that PD3 wrote to HSE solicitors (LA2) on 15 September 2007 and queried legal advice around wardship of SU1 in 1996. LA2 responded on 19 September 2007 indicating that there was no such record of advices in 1996. This has also been directly confirmed to the Inquiry Team by the Solicitors concerned.

6.8.3. The Inquiry Team notes from the file dated 12 December 2007 that PD3 had been "advocating that application be made for SU1 to be made Ward of Court".

6.8.4. The Inquiry Team notes that PD3 was requested to provide a report to LA2 in December 2007 re SU1 and related issues. This report was circulated to the VAC in January 2008 and furnished to the solicitor, with an updated version furnished in March 2008. It is noted that discussion at the VAC meeting of 12 December 2007 indicates that there was a need for "*legal representation to protect HSE and the personnel involved*".

6.8.5. The [REDACTED] prepared a lengthy report for the sole stated purpose of obtaining legal advice. This report is based on a review of relevant files and some

phone conversations and does not appear to the Inquiry Team to contain any assessment of the current risks, if any, posed to SU1. The completed report was forwarded to LA2 and would appear to have been the sole basis for briefing the legal team regarding SU1. This led to advice being given in September 2008 which advocated a Ward of Court application on behalf of SU1. The validity of the content of this report was immediately questioned by other key professionals and thus led to some doubts about the legal advice received, to the extent that this legal advice was not apparently circulated to the [REDACTED]. In the opinion of the Inquiry Team this should not be viewed as raising questions around the quality of the legal advice received. It is regrettable however that the [REDACTED] Report, despite its acknowledged flaws, was permitted to become the sole basis for obtaining legal advice, including advice requested from Senior Counsel. It is noted that an update to the March 08 [REDACTED] Report was provided to Senior Counsel in 2009 but the original report continued to be used as a source of information. The Inquiry Team notes that in the documentation examined, including minutes of VAC meetings, there were a number of references, some speculative, to the strength of the evidence perceived to be required for a successful Ward of Court application to be made. However there is no evidence of management seeking a comprehensive assessment of SU1's current placement in order to strengthen any such application. It was agreed that the SWTL would provide an update to his earlier report.

- 6.8.6. The Inquiry Team notes that at the VAC meeting of 6 March 2008, PD3 is quoted as looking for a "*legal framework to progress*".
- 6.8.7. The Inquiry Team notes that the meeting between LA2 Solicitors, the [REDACTED] H17 and Chair of VAC H27 on 14 March 2008 went ahead notwithstanding PD3's unavailability to attend. The solicitors, LA1, have confirmed to the Inquiry Team that the "*objectivity or lack thereof of the draft report*" was discussed at that meeting. Notwithstanding those discussions, this draft report was furnished to Counsel in September 2008 to secure legal opinion on issues relating to the placement and the possible transfer of SU1.

6.8.8. The Inquiry Team notes that arising from the meeting with the solicitor of 14 March 2008; the following advice was furnished by the solicitor on 26 March 2008 suggesting that:

- The birth mother be contacted and consent sought for various services to be put in place by HSE
- The birth mother was entitled to information pertaining to her child only re the foster placement
- That Mrs. [REDACTED] be encouraged to have SU1 brought to avail of services and if refusal the consent of the birth mother should be used to ensure those matters attended to in the best interests of SU1.

With regard to the question of consent, the LHO1 Solicitors separately confirmed to the Inquiry Team that its advice was that the birth mother's consent was not formally required for a transfer of SU1 to alternative residential care, however it was *"... desirable that if the natural mother would become involved it would be in the best interests of (SU1)"*

6.8.9. The Inquiry Team understands that in an e-mail dated 22 June 2008 to H17, PD3 disputed that the written report provided by him had been considered in the legal advice tabled by LA2 Solicitors. PD3 particularly took issue with the absence of a reference to Ward of Court proceeding and moving SU1 out of the former foster placement. The Inquiry Team notes PD3 was of the view that SUR1 was entitled to know that allegations had been made re other service users in the placement. The Inquiry Team further notes that PD3 expressed the opinion that Senior Counsel's advice be sought and suggested that the HSE were reluctant to go to Court as they feared that the Court would be critical of their record in protecting SU1.

6.8.10. The Inquiry Team understands that LA2 Solicitors was requested on 1 September 2008 to proceed to seek Counsels Opinion re SU1. The Inquiry Team further understands that PD3 was not a party to those discussions. The Inquiry Team notes that in September 2008 LA2 advises contact with the birth mother. LA2 *"suggests that legally we have very few options. If we seek to take the client back into the care of the HSE a judge would need strong evidence of why it is necessary given that she has been in this woman's care for so long. The Judge would need to see that it is in the client's best interest and there is little evidence of this. The court will likely ask what have the*

*HSE being doing for the past years for this client."* LA2 advised that legal counsel's opinion should be sought on the case.

- 6.8.11. The Inquiry Team notes that legal opinion was issued by Barrister LA3 on 26 September 2008. The Inquiry Team notes that PD3 states that this Opinion was not furnished to him or detail of its contents brought to his attention. The Inquiry Team notes that the Opinion, which is stated to have been based on PD3's report to the solicitors, proposed that an application for Ward of Court be processed "*as a matter of urgency*".
- 6.8.12. The Inquiry Team understands that a special meeting called to discuss SU1 on 5 November 2008 heard that the Legal Opinion suggested a Ward of Court route for SU1. The Inquiry Team further understands that discussion took place on whether to instruct solicitors to proceed to apply for Ward of Court. The Inquiry Team understands that PD3 and the PSW (H25) favoured this approach and H17 and H27 reportedly wished to give Mrs. [REDACTED] one further opportunity to comply voluntarily with a request to transfer.
- 6.8.13. The Inquiry Team notes from an e-mail issued by H17 in 21 January 2008 to PD3 and others that planning was now required to proceed to Ward of Court application
- 6.8.14. The Inquiry Team notes an exchange of e-mails involving PD3, the [REDACTED] (H26) and H17 around concerns about what steps might be open if a Ward of Court application was unsuccessful.
- 6.8.15. Following a meeting with Mrs. [REDACTED] on 18 February 2009 attended by H17 and PD3, the Inquiry Team notes that PD3 in an e-mail dated 19 February 2009, suggested seeking Counsels Opinion before going the Ward of Court route. The Inquiry Team notes that PD3 forwarded that e-mail to the [REDACTED], [REDACTED], [REDACTED] and the HSE solicitors. On the following day PD3 e-mailed VAC members and suggested that the Court might be requested to consider the appropriateness of an application before making the full Ward of Court application. The Inquiry Team also understands from the LHO1 solicitor that a discussion took place between the solicitor and the [REDACTED] H26 around seeking further advice from Senior Counsel on the matter. The solicitor has advised the Inquiry Team that the question again arose on the "objectivity" of the draft report provided by PD3.
- 6.8.16. The Inquiry Team notes that PD3 issued an e-mail to LA2 Solicitors 5 March 2009 seeking advice on the HSE's

possible legal exposure in returning SU1 to the care of the FPs pending any attempt to ... protect her in the courts."

- 6.8.17. The Inquiry Team understands that PD3 furnished e-mails to the [REDACTED] and to VAC members on 22, 26 and 27 March 2009 outlining his views on the legal situation re SU1.
- 6.8.18. The Inquiry Team notes that an updated Report was provided by PD3 to the [REDACTED] on 22 April 2009 for the purposes of obtaining legal advice. The Inquiry Team understands that substantive amendments were made to that version of the draft Report as opposed to the version that was forwarded to LA2 solicitors in March 2008 and upon which the legal opinion of September 2008 was based.
- 6.8.19. The Inquiry Team understands that verbal advice was provided by Senior Counsel in early July 2009 to the effect that alternative approaches be initiated other than Ward of Court application. The Inquiry Team understands that the Senior Counsel outlined his verbal advice that a wardship application should not be brought in this case and that an application should be brought to the High Court to remove SU1 from the placement. The solicitor confirmed that Senior Counsel did not indicate what type of application and under what legislation such an application would be brought, but suggested that the type of application to be brought would be for the purpose of moving SU1 from the current placement to a residential placement. The solicitor understood from the Senior Counsel that "*the inherent jurisdiction of the High Court was to be used to make such an application*".
- 6.8.20. The Inquiry Team notes that despite the focus of attention from November 2007 onwards on legal frameworks around actions to be taken by the health professionals involved in respect of protective measures for SU1, that when action was taken to remove SU1, it was done without sight of written legal advice. It is also noted that when written legal advice was obtained in September 2008, which clearly set out the Ward of Court application as being the route to secure transfer to residential placement, this legal advice was not followed. The Inquiry Team is unable to understand why Counsel's Opinion was sought in September 2008 on the basis of a draft Report which members of senior management queried on the grounds of objectivity.
- 6.8.21. The Inquiry Team notes that following the transfer of SU1 from the foster placement to the residential placement in ID1, a view was taken within LHO1 in consultation with its

solicitor that further legal advice was not required, and that any issues regarding the matter of consents in respect of medical care of SU1 could best be dealt with by keeping the birth mother involved in the process and continuing to obtain consents as required from her.

**6.9. *Issues relating to the management of SU1 following transfer to Residential Services***

6.9.1. Following SU1's admission to residential care, staff expressed concern about behaviour displayed by SU1 which they consider to be sexualised. This information was reportedly relayed to PD3 by PD1 on 18<sup>th</sup> September 2009. Around this time, ID1 felt the need to formally raise with the HSE their ongoing concern about SU1's previous placement with Mrs. [REDACTED] and the manner in which the concerns held by the HSE were being followed up, and any implications for other vulnerable adults.

6.9.2. The Inquiry Team notes that on 2<sup>nd</sup> September 2009 a meeting was held between HSE and ID1 to discuss the outstanding issues around the residential placement, including SU1's access to specialist services. The Inquiry Team understands that at this meeting ID1 indicated their intention to seek their own legal advice to assist them in seeing clarity around SU1's legal status, decision making and issues of capacity and consent. The issue as to whether ID1 had sole responsibility for promoting SU1's best interests was raised at this meeting and subsequently became a major issue of contention between ID1 and HSE.

6.9.3. The Inquiry Team has examined the extensive correspondence from September 2009 between the HSE and ID1 in respect of the planning for the supports and future care of SUI. This correspondence included differences around resourcing issues and some diverse views as to the respective responsibilities of both the HSE and ID1 in relation to SU1's care. A backdrop to this was ID1's concern that a full disclosure of information relevant to SU1's care was not made available to ID1 prior to transfer and was not formally made available until November 2009. Further concerns were expressed in relation to the initiation of investigations into allegations centring on SU1's former foster placement. This correspondence is summarised in paragraphs 3.11.40 to 3.11.60 above.

6.9.4. The Inquiry Team understands that the legal advice received by ID1 indicated that they should pursue Wardship

proceedings in respect of SU1 and ID1 proceeded with this application. This subsequently became a significant source of tension between ID1 and the HSE and has contributed to a deterioration in relationships between the two agencies. While the Inquiry Team understands that ID1's decision to seek legal advice in these circumstances was prudent it is regrettable that deteriorating relationships and/or unclear communication led to a situation where a joint application for wardship was not pursued.

#### 6.10. ***Management and Supervision***

6.10.1. The Inquiry Team notes the various recollections of relevant parties on line management arrangements in respect of the [REDACTED] for vulnerable adults (PD3) from his acting appointment in June 2007 until the appointment of the [REDACTED] Children and Families Service in April/May 2008. The Inquiry Team understands that while an [REDACTED] was in position, it has been stated to the Inquiry Team that alternative line management arrangements were put in place. There are varying accounts from the relevant parties as to the clarity of any such arrangements. What is clear is that due to Human Resource related issues, the Inquiry Team understands that reporting relationships between the [REDACTED] and the [REDACTED] were not agreed. The Inquiry Team understands that from the date of appointment of the [REDACTED] (PD3) in June 2007 until the appointment of the [REDACTED] in May 2008 there were no conventional line management arrangements in respect of PD3. The Inquiry Team has been advised by interviewee H22 (former Chair of the VAC), that one of the factors behind the establishment of the Vulnerable Adults Committee in September 2008 was the recognition that such a mechanism would offer support to the Disability Service and in particular to the [REDACTED] in the reported absence of a functioning Social Work line management arrangement. On the other hand the then [REDACTED] recollection was that it was felt that membership of the Vulnerable Adults Committee included other professionals and that it was felt that this would provide the relevant level of supervision for PD3. No documented record of the suggested arrangement was available for examination by the Inquiry Team and there is no evidence that PD3 was aware that the Vulnerable Adults Committee was intended to play a supervisory role. The Inquiry Team is concerned that the lack of clarity around reporting/ line management arrangements for



PD3 in the period June 2007- May 2008, coincided with a crucial period around the management of issues relating to SU1.

6.10.2. The [REDACTED] commenced in post in May 2008 and it was confirmed that the [REDACTED] would supervise the [REDACTED] on a monthly basis. The [REDACTED] indicated to the Inquiry Team that this was to be a "temporary" arrangement as the main focus of his work was Children and Families Services. It was also understood that the [REDACTED] would supervise the [REDACTED]. The files indicate that in September 2008 the [REDACTED] did seek clinical supervision in this case from the [REDACTED] at a time when the [REDACTED] was on extended sick leave. The need for him to receive same was highlighted by the [REDACTED] due to what she perceived as a failure to follow up on a number of recommendations made at VAC meetings. The [REDACTED] has informed the Inquiry Team that he set out a schedule of supervision meetings and that 6 such meetings would have taken place over a 12 month period.

6.10.3. The Inquiry Team has identified concerns which raise questions around the discharge of individual managerial and professional responsibilities of PD3 in the role of [REDACTED] er. These concerns include:

- The inclusion of what could reasonably be stated to be subjective opinion and speculative comment in Social Work reports provided for the purposes of obtaining legal advice regarding SU1's placement
- Ongoing challenges to the *de facto* role of the Vulnerable Adults Committee in co-ordinating the HSE approach to SU1's placement
- The non –provision of information to ID1 Day Services around the potential concerns relating to SU1's placement
- The apparent absence of any active consideration of protective or ameliorative measures regarding SU1's placement, when it was clear that there was no immediate prospect of a Ward of Court application being made

The Inquiry Team would also have a view that on the basis of the factual information available to PD3 by the end of 2007, it would have been reasonable to expect that the following steps be taken;

- That he would have carried out a full investigation/assessment that resulted in a clear documented plan of action
- That he would have formed linkages on an ongoing basis with relevant health professionals i.e. SU1's GP and PHN
- That he would have worked more collaboratively with ID1 to monitor all concerns pertaining to SU1.

6.10.4. The Inquiry Team is aware that in July 2008 the [REDACTED] [REDACTED] informed the [REDACTED] that she was not happy with the [REDACTED] management of the case and requested a meeting to discuss same. On more than one occasion during the period 2008 and 2009, the [REDACTED] voiced her concerns re what she perceived as a lack of action by the [REDACTED] in relation to progressing matters in this case and in particular, following up on decisions taken at the VAC. On the other hand PD3 expressed frustration at what he perceived as failure to take immediate steps to make application for Ward of Court and to remove SU1 from the placement, which PD3 viewed as the only recourse to ensure the protection of SU1. The documentation seen by the Inquiry Team indicates a deterioration in the professional working relationship between PD3 and H17, a feature of which included H17 removing the SU1 case files from the [REDACTED] office without his knowledge. The files also indicate a level of frustration on the part of successive Chairs of the VAC in respect of alleged failure by PD3 to follow up decisions of the VAC. The [REDACTED]s on record as stating that *"a lack of a legal framework is no reason for inaction. We must all act in the clients best interests"*. This disparity of opinion regarding decisions of the VAC not being followed was ongoing throughout the period under review. The Inquiry Team notes the repeated insistence of the [REDACTED] to postpone taking any action in this case other than to await legal advice *".... there was no consensus at this meeting (re actions) as I declined to do anything other than await legal advice."*

It is the view of the Inquiry Team that there was a failure of management to address this ongoing staff issue to ensure that such issues did not present any obstacles to the HSE's

discharging its duty of care obligations to SU1, and the failure to address those issues remained a feature of this case.

6.10.5. The Inquiry Team would have concerns around the management of the transition between the departure of the previous [REDACTED] (H15) and the appointment of H17 to that post in the summer of 2001. H15 provided an account to the Chair of the Inquiry Team which suggested that a "detailed handover" had taken place and that subsequently H17 had clarified a number of issues with her. H15 also stated that she had no recollection as to whether SU1's case would have been referred to in the handover, but expressed the view that given that SU1 was on the priority list "in the top ten" and top of the priority list for placement in ID3, that it was unlikely that H15 would have omitted reference to SU1 in the course of the handover. On the other hand, H17 in her interviews with the Inquiry Team has stated that there was no detailed handover from H15 and no indication that SU1 was a priority. The Inquiry Team notes that H17 corresponded with ID3 in August 2001 and was advised by that service provider of the need for contingency arrangements to be in place if "an emergency arises". Although H17 has advised that it is not part of her role to read client files and that she did not read SU1's file in 2001, the Inquiry Team notes that H17 was sufficiently informed of the circumstances relating to SU1 at that time to equip her to advise the birth mother by telephone in September 2001 of the current arrangements and the fact that SU1 would not be moving placement. The Inquiry Team notes that H17's involvement with SU1's placement and her communication from the birth mother in September 2001 does not appear to have been shared with the VAC when SU1's placement was being considered in 2007-2009. The [REDACTED] has also disputed that such information was furnished to him as claimed by H17. The Inquiry Team would be of the view that such information was pertinent as an important background factor in assessing the suitability of the placement from 2007. The Inquiry Team further notes that a specific decision taken by the VAC to have the [REDACTED] inform ID1 about concerns re SU1 and the placement, was not apparently followed through, with no explanation evident as to why this decision was not implemented. Having regard to the above, it is the view of the Inquiry Team that this suggests a lack of overall effective management in this case and further suggests issues of individual professional accountability which may need to be addressed by the HSE.

6.10.6. One particular example of a potential failure to discharge management responsibilities relates to the provision of the

██████████ (PD3's) report as the basis for obtaining legal advice from Counsel in September 2008. This same report had been discussed with the LHO solicitor in March 2008 with reference to its "objectivity or lack thereof". Following the provision of Counsel's Opinion in September 2008 concerns were almost immediately expressed by management about the validity of the opinion given that it was based on information which allegedly lacked objectivity. At this remove the Inquiry Team cannot understand why there was no effective management intervention to ensure that whatever the concerns were around alleged lack of objectivity, that these could have been addressed prior to time and money being spent on obtaining Counsel's Opinion.

- 6.10.7. The Inquiry Team would note that throughout the period under review, other than for a time in mid - 2002, there was an allocated Health Board/ HSE professional assigned with a responsibility for SU1 as a named priority or at least assigned to an overall Foster Care, Child Protection or latterly Adult Protection function. Accordingly, the Inquiry Team would conclude that the lack of decisive interventions in the best interests of SU1 cannot reasonably be attributed to a lack of resources. For example, from June 2008 there were 3 Social Work professionals between the LHO and the Day Service provider available to monitor this case, two of whom had the support of the ██████████ if required. The VAC was operational ostensibly with a working Adult Protection policy in place. There was also a ██████████ in ID1 although the Inquiry Team would acknowledge that the ID1 resources were not fully utilised in the absence of adequate disclosure by the LHO of current and historical welfare and protection issues for SU1.

## **7. Observations/Recommendations to Reduce the Likelihood of Future Harm Arising From Matters Identified in Findings**

### **7.1. *Introduction***

7.1.1. The following observations/recommendations have been arrived at having regard to the information gathered in the course of this Inquiry and in particular the findings arrived at following an examination of that information. The observations/recommendations set out below are intended for general application within the HSE as well as specific application in the HSE LHO area which had responsibility for the care and management of SU1. Where specific concerns have been identified by the Inquiry Team in respect of duty of care and individual and collective responsibility issues, it will be a matter for the HSE to examine those findings and determine whether any additional processes are merited in respect of any individual or individuals.

7.1.2. The Inquiry Team recognises that many of the recommendations set out below will require to be assessed by the HSE under risk reduction and quality improvement headings and may require appropriate action plans if those recommendations are to be implemented.

### **7.2. *Policy Considerations***

7.2.1. As a matter of urgency the HSE should finalise and adopt a policy for the protection of vulnerable adults with a disability for uniform application throughout the HSE.

7.2.2. The HSE should ensure that the policy for the protection of adults with a disability referred to in 7.2.1 above is also adopted by all voluntary bodies and nominated service providers.

7.2.3. The HSE should designate a responsible officer in each former Local Health Area [LHO] to ensure that:

- (a) There are clear and practical protocols between the HSE and other service providers in respect of the care and management of vulnerable adults with a disability

(b) There is a uniform application of protective measures in respect of vulnerable adults in all HSE approved/funded placements

(c) There are relevant training modules sourced to be delivered to HSE and voluntary agency staff who would be expected to have a role in adult protection and safeguarding work

7.2.4. The HSE should develop a clear governance structure to be implemented by the HSE and other relevant agencies to support the placement of adults with a disability in family type settings

7.2.5. Consideration should be given to developing a protocol around contact between service users and their families, being mindful of service users wishes.

7.2.6. Having regard to the set of circumstances highlighted in this Protected Disclosure Inquiry, the Inquiry Team also wishes to make the following observations under this heading:

- There is a requirement for consistency in respect of communication with relatives of a vulnerable adult who may not be in regular contact with that person and who may not be in a position to advise on what would be in the best interests of the vulnerable adult at the time a decision is required to be made
- Where there are concerns about the appropriateness or suitability of a placement, this should be taken into account in determining the weight to be attached to the views of any such person managing or having control over that placement

### **7.3. *HSE liaison with other agencies around Adult Protection concerns***

7.3.1. There should be ongoing comprehensive documentation and exchange of adult protection concerns as between the HSE and any of the relevant voluntary providers of services to any such vulnerable adult. A National policy for the protection of vulnerable adults with a disability should underpin such practice and should ensure that there are reciprocal obligations applied to the relevant voluntary agency.

7.3.2. Pending the introduction of formal protocols for liaising with An Garda Síochána in cases of suspected abuse of vulnerable adults, the Inquiry Team would recommend that equivalent protocols such as those in place for the protection and safeguarding of children (Children First) be adopted as an interim measure and that clear protocols are ultimately included in a national protection of vulnerable adults with a disability.

### **7.4. *Social Work and Management Issues***

7.4.1. Social Work management should ensure that staff working in this area receive appropriate supervision, direction and support to ensure that their practice in the protection and support of adults with an intellectual disability is of a high standard.

7.4.2. Social Work Management need to more clearly define the role of the Social Work professionals vis a vis both the wider Social Work and Intellectual Disability Services. Reporting relationships, roles, responsibilities and accountability arrangements must be clearly defined so as to provide a clear operational and strategic context within which those professionals can deliver an effective service. The Inquiry Team notes that Statutory Instrument No. 143 of 2011, 'Code of Professional Conduct and Ethics for Social Workers Bylaw', has been introduced as part of the legislation framework for social workers in accordance with the Health and Social Care Professionals Act 2005, as part of a new regulatory framework for social workers and other health professionals. The Inquiry Team understands the registration process is underway and that it is anticipated that all social workers will be registered and will be subject to the code of professional conduct and ethics by the end of 2013. The Inquiry Team would suggest that in the interim, it would be appropriate for both Management and Social Work professionals to have regard to the provisions of SI 143 of 2011 as a quality benchmark to assist in meeting standards that should reasonably be expected

in respect of Social Worker and Management interventions, particularly with regard to children and vulnerable adults. The Inquiry Team would note the following provisions of the code pertinent to the issues which have been the subject matter of this Inquiry.

- " 8. *Demonstrating Professional accountability*  
*You must be prepared to explain and account for your actions and decisions.*
9. *Acting in the best interests of service users*
  - a) *You are responsible for acting in the best interests of service users*
  - b) *You must:*
    - *treat service users as individuals;*
    - *respect diversity, different cultures and values and not condone, facilitate or collaborate with any form of discrimination;*
    - *respect and, where appropriate, promote or advocate the views and wishes of service users and carers;*
    - *support service users' rights to take part in all aspects of the service and to make informed choices about the service they receive;*
    - *help service users to reach informed decisions about their lives and promote their autonomy. Any action which diminishes service users' civil or legal rights must be ethically, professionally and legally justifiable;*
    - *make service users aware that their interests may be overridden in circumstances where the service user's interest is outweighed by the need to protect others;*
    - *when working in a team, be responsible for your professional conduct, for any service or professional advice you provide and for your failure to act;*
    - *protect service users if you believe that they are threatened by a colleague's conduct, performance or health. The safety of service users must always come before any personal and professional loyalties;*
    - *discuss the matter with an appropriate professional colleague if you become aware of any situation that puts a service user at risk;*
    - *work in line with the principles of human rights and social justice. You may be required to support service users to take risks to allow them to reach their full potential and well being. You should be*



*mindful of the affects these risks may have on the service user and other, particularly children and vulnerable adults."*

- 7.4.3. Social Work Professionals should ensure that risk assessments in Adult Protection cases are holistic and consider all aspects of the person's life so that this will in turn inform a Protection Plan which can be used to deliver effective protection and support to the Service User.
- 7.4.4. Social Work Management, together with Intellectual Disability Service Management, should ensure that there is an effective case management process in place within the Disability Service which allows Social Work professionals to prioritise cases in line with best practice and ensure service delivery is of a high standard.
- 7.4.5. As a matter of urgency Social Work and Disability Management should ensure that there is a robust process in place for the documented handover of cases and that the effectiveness of this is monitored.
- 7.4.6. Social Work Management should ensure that decisions taken at meetings for follow up by Social Workers are actioned and that clear effective mechanisms for dealing with non compliance are put in place.
- 7.4.7. Social Work and other staff in Intellectual Disability Services should receive appropriate training on file and record keeping. The present system should be comprehensively reviewed.

## **7.5. Human Resource Policy Considerations**

### ***The HSE Disciplinary Procedure 2007***

- 7.5.1. The Inquiry Team notes the provisions of the Disciplinary Procedure for Employees of the Health Service Executive – January 2007. One of the principles that applies to the disciplinary procedure is that every effort will be made by the employee's immediate supervisor/ manager to address shortcomings in work standards, conduct or attendance through informal counselling without invoking the disciplinary procedure.
- 7.5.2. The Inquiry Team also notes that in addition, the policy envisages that all employees adhere to the required standards

by being made aware of any shortcomings by their line manager and by identifying how the necessary improvements can be achieved. The key objective is to assist the employee to maintain the required standards, rather than impose penalties. However where the employee's conduct does not meet the required standards despite informal counselling and support, such performance issues are to be dealt with under the Disciplinary Procedure.

- 7.5.3. Having regard to the above principles, the Inquiry Team recommends that line managers within the HSE Local Area that has been the subject of this Inquiry be reminded of their responsibilities for making employees aware of the standards of work and conduct expected from them and in the absence of such standards being met, that any such shortcomings be dealt with promptly and fairly.

## **7.6. *Performance Issues***

- 7.6.1. The Inquiry Team would strongly recommend that consideration be given by the HSE to the implementation of a formalised performance management /appraisal system. The Inquiry Team's understanding is that such a system would involve a review and discussion of an employee's performance of assigned duties and responsibilities. It may be appropriate to consider including the satisfactory compliance with professional development criteria in any such performance system. The Inquiry Team understands that CORU, the regulatory body for Health and Social Care Professionals, will be introducing Continuing Professional Development criteria as part of its requirements for social workers and other health care professionals to continue to be statutorily registered.

## **7.7. *Historical Issues***

- 7.7.1. The Inquiry Team has corresponded extensively with the HSE following its examination of files relating to historical concerns of alleged abuse referenced in reports prepared by PD3 for the purposes of obtaining legal advice relating to SU1's placement with the [REDACTED]. These issues were examined by the Inquiry Team to establish whether the professionals involved in managing SU1's placement had knowledge of these issues and whether such concerns were appropriately assessed to determine the suitability of the placement for SU1. The Inquiry Team is advised that the inclusion of specific detail relating to those allegations may be outside the terms of reference of this

Inquiry. Accordingly, the Inquiry Team, in order to discharge its responsibilities to the Commissioning Body (the HSE) separately detailed the allegations relating to other service users and recommended that the HSE satisfy itself that those historic issues be examined in full and appropriately addressed. The Inquiry Team notes that a working group was established in November 2009 by the LHO Manager to look at historical issues highlighted relating to concerns by service users on placement with the [REDACTED]. The Inquiry Team would recommend that the HSE would in particular consider the following considerations relating to specific service users as set out below.

## **SU2**

7.7.2. The Inquiry Team has recommended that the HSE would separately address specific questions relating to a different service user (SU2) arising from the examination by the Inquiry Team of files relating to the period 1996 – 1997 broadly relating to the following areas:

- Decisions not to proceed to investigate following the notification of allegations/complaints relating to SU1 having regard to the Child Protection Policy in place in the Heath Board area at that time.
- Whether the duty of the HB3 to investigate the claims to the extent that was possible in the circumstances, was discharged

In undertaking any such review of historic issues, the HSE should also have regard to Mrs [REDACTED] accounts to the Inquiry Team that the identity of the complainant/ former resident SU2, was not revealed to Mrs [REDACTED] nor was Mrs [REDACTED] questioned about any recollection of that service users placement.

## **SU3**

7.7.3. Following its examination of the available files relating to allegations of historical abuse of SU3, the Inquiry Team recommends that the HSE establish the facts around disclosures of possible abuse linked to the placement which is the subject of this Inquiry.

## **SU4**

7.7.4. The Inquiry Team recommends that the HSE would assess the appropriateness of linking any historic concerns

relating to this service user with the placement which is the subject of this Inquiry.

### **SU5**

- 7.7.5. The Inquiry Team recommends that the HSE would establish the facts around alleged physical mistreatment of SU5 while on respite in the placement which is the subject of this Inquiry.

## **7.8. Vulnerable Adults and the Law**

- 7.8.1. The Inquiry Team notes the complexities associated with seeking legal resolutions to care and protection issues relating to vulnerable adults who are suspected of being at risk. These complexities were fully considered in the Law Reform Commission Consultation Paper on Vulnerable Adults and the Law's Capacity [LRC CP 37-2005]. That paper did not consider the circumstances around the question of consents in respect of the placement/removal of vulnerable adults outside of designated mental treatment facilities. It did however give full consideration to case law at that time in respect of the appropriate consents around medical treatments/interventions in respect of a vulnerable adult. The Inquiry Team acknowledges that if an adult lacks the capacity to make a decision on healthcare, as a general rule, no other party has the legal right to make a decision on their behalf. The Inquiry Team further acknowledges that in the case which is the subject of this Inquiry, ultimately the decision was taken to address this capacity/consent issue through the utilisation of the Ward of Court proceedings. The Inquiry Team notes that there are mixed views on the appropriateness of the utilisation of such procedures but also recognises that in the absence of alternative means to achieve clarity on consent/capacity issues it remains, as stated by the Law Reform Commission in its *"Report on Vulnerable Adults and the Law"* [LRC 83-2006] as an *"archaic and complex"* system. As the Law Reform Commission states in its Consultation Paper on Law and the Elderly [LRC CP 23-2003] *"The Ward of Court system is cumbersome and outdated. The language and concepts used in the legislation are inappropriate to the current understanding of mental illness, mental impairment and legal capacity. The basis of the jurisdiction is not clear, the procedures are lengthy and too many decisions have to be referred to the President of the High Court. The powers and duties of the appointed Committee are*

*not clear and the legislation does not deal with how decisions about the person of the Ward are to be made..."*

7.8.2. The Inquiry Team would also acknowledge that in response, in part, to the capacity and consent issues highlighted by the Law Reform Commission, the Oireachtas is considering specific provisions addressing a number of core issues, including a potential alternative route to clarifying consent and capacity issues for vulnerable adults without the necessary recourse to Ward Of Court Proceedings or other alternative applications to the High Court to secure authorisation for actions in the "best interests" of a vulnerable adult (Mental Capacity and Guardianship Bill [2011]). The Inquiry Team would note with approval the principles underpinning that legislation, including:

(a) no intervention is to take place unless it is necessary having regard to the needs and individual circumstances of the person including whether the person is likely to increase or regain capacity;

(b) any intervention must be the method of achieving the purpose of the intervention which is least restrictive of the person's freedom;

(c) account must be taken of the person's past and present wishes where they are ascertainable;

(d) account must be taken of the views of the person's relatives, primary carer, the person with whom he or she resides, any person named as someone who should be consulted and any other person with an interest in the welfare of the person or the proposed decision where these views have been made known to the person responsible;

(e) due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy.

7.8.3. The Inquiry Team would strongly recommend that the provisions of the Mental Capacity and Guardianship Bill (2011), once it becomes law, would be utilised by the HSE to secure timely and appropriate clinical and other care interventions where there is any legal ambiguity around the appropriate interventions to be made in respect of a vulnerable adult.

## 8. Acknowledgements

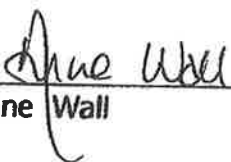
- 8.1.1. The Inquiry Team wishes to acknowledge the co-operation of those individuals who attended for interview and corresponded with the Inquiry Team in the course of this process.

Signed:   
Conal Devine, Chairman

Date: 28/3/2012

  
Breda Mulvihill

Date: 28/3/2012

  
Anne Wall

Date: 28/03/2012



**I. List of parties interviewed and/or corresponded with in the course of the Inquiry**

| Disclosers                         | No of Interviews | Corresponded with | Issued with draft findings |
|------------------------------------|------------------|-------------------|----------------------------|
| ██████████ PD1                     | 3                | ✓                 | ✓                          |
| ██████████ PD2                     | 2                | ✓                 | ✓                          |
| ██████████ PD3                     | 3                | ✓                 | ✓                          |
| <b>Foster Placements</b>           |                  |                   |                            |
| SU1 placement 1989 - 2009          | 2                | ✓                 | ✓                          |
| SU1 placement pre 1989             | 0                | x                 | x                          |
| <b>Service Users and Relatives</b> |                  |                   |                            |
| Service User SU1                   | 0                | X                 | x                          |
| Birth mother SUR1                  | 0                | ✓                 | x                          |
| Service user SU2                   | 0                | X                 | x                          |
| SU2's mother SUR2                  | 0                | X                 | x                          |
| Service user SU3                   | 0                | X                 | x                          |
| Service user SU3's mother          | 0                | X                 | x                          |
| Service user SU4                   | 0                | X                 | x                          |
| Service user SU5                   | 0                | x                 | x                          |
| <b>HSE/Health Board Staff</b>      |                  |                   |                            |
| ██████████ H1                      | 0                | -                 | -                          |
| ██████████ H2                      | Refused          | ✓                 | X                          |
| ██████████                         | 1                | ✓                 | ✓                          |
| ██████████ H4                      | 1                | ✓                 | ✓                          |
| ██████████ H5                      | 1                | ✓                 | X                          |
| ██████████ H6                      | 1                | ✓                 | ✓                          |
| ██████████ H7                      | 1                | ✓                 | ✓                          |
| ██████████ H8                      | 1                | ✓                 | ✓                          |
| ██████████                         | 1                | ✓                 | ✓                          |
| ██████████ H10                     | 0                | ✓                 | ✓                          |
| ██████████                         | 0                | -                 | -                          |
| ██████████ H12                     | 1                | ✓                 | ✓                          |
| ██████████ H13                     | 1                | ✓                 | ✓                          |
| ██████████ H14                     | 1                | ✓                 | ✓                          |
| ██████████                         | By telephone     | ✓                 | ✓                          |
| H15(up to June 2001                |                  |                   |                            |
| ██████████ H16                     | By telephone     | ✓                 | ✓                          |
| ██████████                         | 3                | ✓                 | ✓                          |
| ██████████ H18                     | 1                | ✓                 | ✓                          |
| ██████████ H19 (up to May 08)      | By telephone     | ✓                 | X                          |
| ██████████ H21                     | 1                | ✓                 | ✓                          |



| <b>HSE/ Health Board Staff</b>                                     | <b>No of Interviews</b> | <b>Corresponded with</b> | <b>Issued with Draft Findings</b> |
|--|-------------------------|--------------------------|-----------------------------------|
| ██████████ (up to mid 08) H22                                      | 1                       | ✓                        | ✓                                 |
| ██████████ H23   | 1                       | ✓                        | ✓                                 |
| ██████████ (from May 08) H25                                       | 1                       | ✓                        | ✓                                 |
| ██████████ H26 (from May 08)                                       | 1                       | ✓                        | ✓                                 |
| Chair of VAC (from May 08) H27                                     | 1                       | ✓                        | ✓                                 |
| ██████████ H28 (from late 08)                                      | 0                       | X                        | X                                 |
| ██████████ H29 (late 96)   | 0                       | X                        | X                                 |
| ██████████ H30 (& Acting from May 07)                              | 1                       | ✓                        | ✓                                 |
| <b>Intellectual Disability Service Provider Staff</b>              |                         |                          |                                   |
| ██████████ ID1 Day Services  | 1                       | ✓                        | ✓                                 |
| SP1 (from '87 - 2008)  |                         |                          |                                   |
| ██████████   | 1                       | ✓                        | ✓                                 |
| SP2 (from 31/3/08)   |                         |                          |                                   |
| ██████████   | 0                       | X                        | X                                 |
| ██████████ ID2, SP4  | 0                       | X                        | X                                 |
| ██████████ ID3, SP5  | 1                       | ✓                        | X                                 |
| <b>Legal Advisors</b>  |                         |                          |                                   |
| Solicitor with LA2 Solicitors, LA1                                 | 0                       | X                        | X                                 |
| Health Board Solicitors, LA2                                       | 0                       | ✓                        | ✓                                 |
| Junior Counsel, Sept 2008, LA3                                     | 0                       | X                        | X                                 |
| Senior Counsel, June/July 09, LA4                                  | 0                       | X                        | X                                 |
| (ID1 Solicitors re Ward of Court application Sep 09 – Mar 10), LA5 | 0                       | X                        | X                                 |
| Solicitors representing H7, LA6                                    | 1                       | ✓                        | ✓                                 |
| Solicitors representing H17, LA7                                   | 1                       | ✓                        | ✓                                 |
| Solicitors representing H18, LA8                                   | 0                       | ✓                        | ✓                                 |
| <b>Other Parties</b>   |                         |                          |                                   |
| An Garda Siochana  | 1                       | ✓                        | X                                 |
| Former Foster Mother, Mrs. ██████████                              | 1                       | ✓                        | ✓                                 |