

**Review of current practices for the protection of  
service users within the Brothers of Charity services  
Galway.**

**Jan – April 2006**

**By**

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## **Introduction**

Ms. Breda Mulvihill and Mr. Paul Murphy were requested by Mr Ger Growley Assistant Director HSE West in December 2005 to review the current practices for the protection of service users within the Brothers of Charity Services Galway.

From 1997 to 1998 a number of allegations of past child abuse within a school as part of the Brothers of Charity services came to the attention of the Western Health Board. As a result of concerns in relation to the allegations the HSE (Western Health Board as it was known at the time) set up an inquiry at the request of the Brothers of Charity in 1999. One of the terms of reference of that inquiry related to “examining policies and procedures in place in the Service”. This work had not been commenced as part of the inquiry. Late in 2005 concern was expressed that the inquiry had not concluded its work and would not be in a position to report for some months. The HSE West decided that an up to date examination of current service user safety was required.

## Terms of reference

The following terms of reference were agreed in February 2006.

- Review all written policies, guidelines, protocols, procedures etc relating to any aspect of the protection of service users.
- To examine the documentation of allegations, complaints, incidents with regard to the protection of service users for the years 2004 and 2005.

For the purposes of this review the term protection covers the following, as outlined in “*Action on Adult Abuse Guidelines*” February 2005 HSE Western Area:

Physical Abuse  
Sexual Abuse  
Psychological Abuse  
Financial Abuse  
Neglect  
Discriminatory Abuse  
Social Abuse  
Emotional Abuse

The review will not apply to general Health and Safety requirements except where they relate to the categories above.

*Phase one and phase two*

The process was divided into two time phases. Phase one - an examination of the written documentation to be completed by 31<sup>st</sup> of March 2006. Phase two - the establishment of the standards of safety practice at an operational level. At the time of writing there is no agreed timescale for this part of the review.

Phase one of the review concentrated on the data contained in written documentation. Mr John Leinster, Head of Social Work Department was nominated as the liaison person on behalf of the Brothers of Charity Services, Galway and he organised access to the various and considerable documentation required.

As part of the review a series of meetings were held:

- 13/01/06 Meeting with Mr Frank Murphy, LHO Manager Roscommon.
- 03/02/06 Meeting with Mr Ger Crowley, Assistant National Director Western Region, Mr Frank Murphy, Ms Patricia Tully, Director of Disability Services HSE West, and Ms Mary O Donnell, Disability Services Manager HSE West.
- 15/02/06 Meeting with Mr Frank Murphy, Mr Patrick McGinley, Director of Services, Brothers of Charity Galway Services, and Mr John Leinster, Head of Social Work Department, Brothers of Charity Galway Services.
- 15/02/06 Meeting with Ms Patricia Tully.
- 30/03/06 Meeting with Mr Patrick McGinley and Mr John Leinster.
- 13/04/06 Meeting with Mr Patrick McGinley, Mr John Leinster and Mr Sean Conneally, Head of Training, Development and Evaluation, Brothers of Charity Services, Galway.
- A draft copy of the report was sent to Brother of Charity Services Galway on the 21<sup>st</sup> of April. On the 16<sup>th</sup> of May reviewers met with Mr Patrick McGinley and Mr John Leinster to discuss additional information for consideration.

## **Background to the Brothers of Charity Services, Galway**

### Mission Statement Brothers of Charity Services Galway

“We support people to be valued citizens in their local community, to have ordinary life experiences and to be closely connected to family and friends. We are committed to supporting people to make choices about their lives and to the provision of quality services that meet people’s needs” (2004 annual report).

### Background and History

The Brothers of Charity congregation was founded in Ghent, Belgium in 1807 and established its first service in Ireland at Belmont Park, Waterford in 1883. In 1949 the Brothers of Charity acquired Kilcornan House in Galway with the objective of providing services to adult persons with an intellectual disability. In 1952 the service was officially opened. By November 1958, there were 100 residents and a religious community of 10 brothers residing in the main house.

The Brothers of Charity at present have centres located in Clare, Cork, Galway, Limerick, Roscommon and Waterford and continue to play a major role in the provision and development of services in intellectual disability services in Ireland.

### Introduction to Brothers of Charity Services Galway

The Brothers of Charity Services Galway today support approx 964 clients with a staff of 701.23 WTE’s. The organisation provides a range of services – (Community, Day, Residential, Supported living and Respite) for persons with an intellectual disability.

**Table 1 Overall Number of Service Users 2004 – Annual Report 2004**

Service	Overall total	Community Services <sup>1</sup>	Day Services	Residential Services	Supported Living	Respite (Recipients in brackets)
Children's Services	463	357	106	6		12 (45)
West Galway Adult Services	263	80	171	132	33	13.5(40)
East Galway Adult Services	238	30	210	146	7	6 (33)
<b>Total</b>	<b>964</b>	<b>467</b>	<b>487</b>	<b>284</b>	<b>40</b>	<b>31.5 (118)</b>

<sup>1</sup> Community Services include individuals in our Early Childhood Services, individuals in ordinary schools getting support from School Age Teams and adults in our Aftercare Services receiving Multidisciplinary Team Supports.

Table 2 Service User Ability and Age Range within Brothers of Charity Services – Annual Report 2004

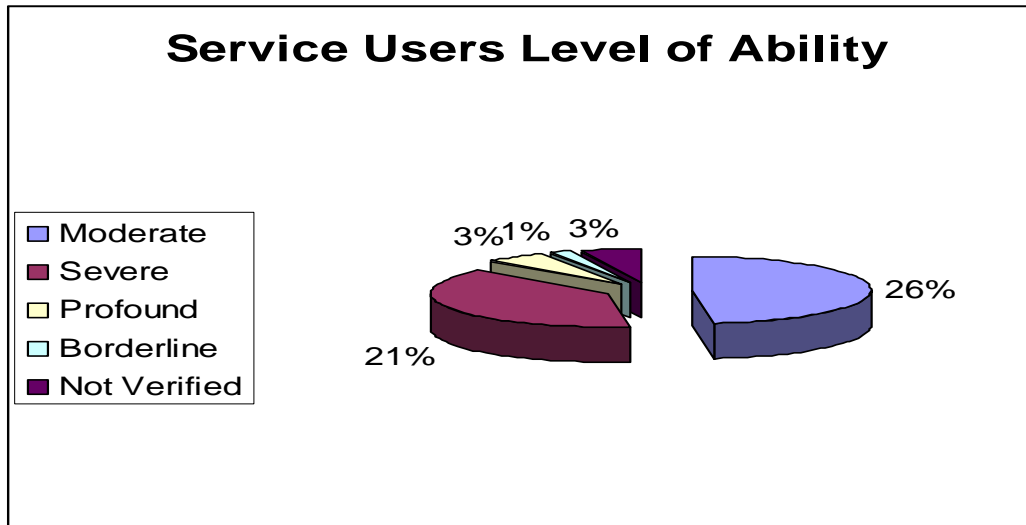
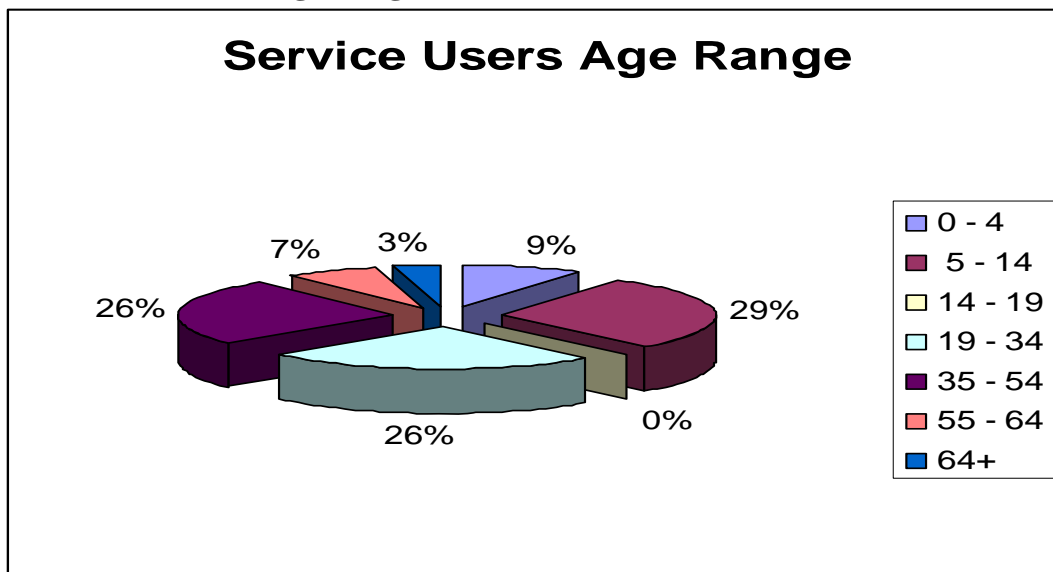


Table 3 Service Users Age Range



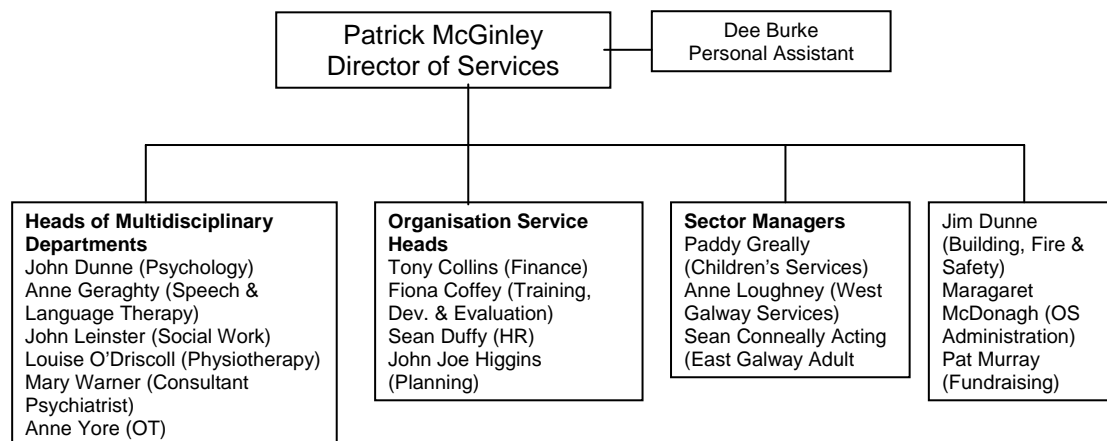
#### Profile of Staff

The Galway services had 885 people in employment at the end of December 2004, which equated to 701.23 WTE's<sup>2</sup>.

<sup>2</sup> See Appendix A & B for Analysis of staff 2004 & Occupational Category

Table 4 **Brothers of Charity, Galway Services Current Organisation Structure May 2006:**

**Brothers of Charity Galway Services – Organisation Structure**



*Referenced in Brothers of Charity Galway Services Directory of Services*

Accountability Structure of Brothers of Charity

The Galway services are part of a provincial structure covering Ireland and the UK. Br John O' Shea is the provincial superior. There are two national directors of services (one for Ireland and one for England) Ms Winifred O Hanrahan Brothers of Charity Services Ireland and Br Alfred Hassett Brothers of Charity Services UK. Mr Patrick Mc Ginley reports to Ms Winifred O Hanrahan National Director of Services Ireland.

Decision-making at a local level is the responsibility of Mr Patrick McGinley in collaboration with his service managers in line with Brothers of Charity services policy.

Regional Council

A regional council is in place since 2001 and acts as an 'advisory governance group' under the chairpersonship of Mr Seamus Keating. The regional council exercises the motivation and guardianship functions of the regional team at local level. The council

reports directly to the regional team of the Brothers of Charity congregation. The council comprises of:

- Two elected family representatives
- Two elected staff representatives
- Two adult service user representatives
- Three nominees of the regional team
- A member of the Galway services directorate

The council meets monthly and it considers a wide range of issues in its deliberations. Any council member is free to bring any issue on to the agenda and the Director of Services gives a formal report at each meeting. Brothers of Charity services Galway will become an incorporated limited company with a board of directors from 01/01/07.

#### Service Provision

Brothers of Charity Galway have subdivided into the following areas for the provision of services; East Galway Adult Services, West Galway Adult Services and Children's Services.

#### East Galway Adult Services

East Galway Adult Services comprises of a range of services to meet the needs of adults and includes the entire county east of and south of Galway city including services based in Athenry, Ballinasloe and Clarinbridge, Gort and Loughrea. A broad range of services are provided to meet the needs of adults including day, residential, respite and a range of support services. See Appendix C

#### West Galway Adult Services

West Galway Adult Services comprises of a range of services to meet the needs of adults and includes Galway city, Connemara and the west of the county. A broad range of services are provided to meet the needs of adults including day, residential, respite and a range of support services. See Appendix D

### Children's Services

The Children's Services comprises of a range of services to meet the needs of children with a learning disability in County Galway. They work closely with other agencies and service providers including local pre-schools, schools, Department of Education and Science, and the Galway Association. See Appendix E

All of the above services are supported by Multidisciplinary Services and the Organisational Services (Administration and Secretarial Services, Database Service, Facility Management Service, Finance Department, Fundraising Coordinator, Information Technology Services, Human Resource Dept, Occupational Health Service, Pastoral Care Service Planning Department and the Training, Development and Evaluation Department) within the Brothers of Charity Services Galway.

## Policy Review

### Overview

The Brothers of Charity have 57 policies on a variety of subjects. 26 of these policies were examined to see if they had relevance to the terms of reference. From this list 7 policies were identified which directly related to the protection and safe care of service users. These are described in Table 5:

**Table 5 Core Protection Policies relating to the terms of reference**

<b>Policy Number</b>	<b>Policy Title</b>
1991/01	Reporting abuse.
2001/04	Policy on confidentiality and the investigation or treatment of sexual abuse where the person making the allegation is an adult.
2002/04	Guidelines for the investigation and for the protection of Adults and Children with a learning disability from Sexual Abuse in Brother of Charity Galway Services.
2002/05	Good practice guidelines for protection against abuse.
2003/06	Complaints Procedure.
2004/01	Guidelines for the investigation of complaints against staff members of incidents of abuse.
2004/04	Policy on reporting and managing aggressive/assaultive behaviour by service users.

Four other policies were identified as relevant as outlined in Table 6:

**Table 6 Related Policies**

<b>Policy Number</b>	<b>Policy Title</b>
1996/02	Garda Clearance
1998/03	Policy on Induction
2001/01	Recruiting and Supporting Workers
No Number	Policy on staff training and development

Each policy was assessed using a template developed by the MWHB in consultation with the National College of Ireland entitled “*A Model for policy formulation and*

*implementation for the Mid Western Health Board disability directorate”* October 2003. An example is contained in Appendix F.

### Comments regarding policies<sup>3</sup>

There is a great deal of information contained in the various policies with direct relevance to the protection of service users. They contain very helpful information on defining abuse and recognising behaviours and attitudes that are considered abusive practices in a care setting. However, policies do not clearly outline the steps for the reporting of an allegation of abuse from its initiation to its actual closure, regardless of abuse type or identity of perpetrator.

#### *Reporting Abuse Policy*

This policy is located in residential services (attached to diaries and the report book), which makes it accessible to staff. It encourages staff to discuss any concern with their line manager and the Social Work service. It is clear about incidents between service users.

#### *Policy on Confidentiality and the Investigation or Treatment of Sexual Abuse where the person making the allegation is an adult.*

This is a helpful policy to have in place and should be incorporated into one main policy on service user safety. For example it could be part of “Guidelines for the Investigation and for the Protection of Adults with a Learning Disability from Sexual Abuse in the Brothers of Charity Galway Services” or attached as an addendum.

#### *Guidelines for the investigation and for the protection of Adults and Children with a Learning Disability from Sexual Abuse in the Brothers of Charity Services Galway.*

The title of this policy relates to sexual abuse but the scope of the policy references other types of abuse. It might be useful to outline the process for investigation of all types of abuse in one document considering that all types are identified. Clear process/processes should be outlined in a policy /policies regardless of perpetrator and abuse type (as identified within the terms of reference).

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<sup>3</sup> See appendix G for detailed comments on each individual policy examined

The role of designated officer/ investigation team/ sector manager detailed in policies is not very clear. Therefore, it is difficult to ascertain who has the ultimate responsibility for the investigation from initiation to closure.

A client protection panel (which would consist of staff from the Brothers of Charity Services and outside agencies e.g. HSE) as highlighted in one of the policies would be a very good forum to ensure that all allegations of abuse are reviewed to ensure client protection and safety and conformity to Best Practice. This, to date, (though stipulated in policy) has not been adopted. If implemented it would be advisable to include all allegations of abuse regardless of type, in the review.

The Brothers of Charity Services are very clear on their reporting responsibility to the HSE when the client is a child, however the detail and the recording of the initial concern is not clearly outlined in the policy.

Review of the policy demonstrates that The Brothers of Charity Services Galway have no formal structure in place to inform the HSE of an internal investigation pertaining to an abuse allegation when the victim is an adult.

The Brothers of Charity Services Galway have no formal structure in place to inform the Gardaí of an internal investigation pertaining to an abuse allegation when the victim is an adult. No clear guidance provided in the policy document as to when Gardaí should be notified.

*Good Practice Guidelines for Protection against Abuse*

This is an excellent document and sets out the standards of safe care for service users.

This policy identifies the proactive steps developed by the Brothers of Charity for the protection of service users against abuse e.g.:

- Good Practice in Communication and Interaction with service users.
- Guidelines for Good Practice in Intimate Care.
- Guidelines for Working with Service Users of the Opposite Sex.
- Good Practice Guidelines for staff Working alone with Service Users.
- Safety and Good Practice regarding Visitors to Group Homes.
- Good Practice regarding Social Outings with Service Users.

- Guidelines for Good Practice on Home Visits.
- Staff support in the client protection process.

The policy does not reference Brothers of Charity Galway services recruitment and selection procedures, Garda Clearance policy, staff training policy, induction policy, all of which are very good policies and are also proactive in protection against abuse. As there is some duplication between this policy and other policies relating to abuse, it might be better used as an addendum to one main policy on abuse.

*Complaints Procedure.*

This is a standard complaints procedure without any particular relevance to safety. We are working on the assumption that safety is enhanced by a range of actions, which promote the dignity of service users. Complaints procedures and processes correctly used will add to the rights of clients and thus enhance protection from harm. The Brothers of Charity services have some service users who will be unable to complain and a full policy should address ways that they can be given a voice. The role of family member, staff etc in complaints could be elaborated.

The procedure promotes the use of a complaints file and an annual review by the Evaluation Department of each team.

*Policy on Reporting & Managing Aggressive/Assaultive Behaviour by Service Users.*

This policy is very similar to the policy on reporting abuse. There is something inherently different between abuse carried out by individuals who are aware of the implications of their actions and behaviour by service users who lack this ability. The effect of the action may be the same on the victim and there is a need to continue to focus on their protection whether or not the actions of others are abuse or behavioural management issues. There is a reference to a 'good practice committee' but it is not clear of the relevance of this committee to protection issues.

*Guidelines for the investigation of complaints against staff members of incidents of abuse.*

There is no reference to the national document *Trust in Care*. It is recommended that this be adopted and incorporated in local policy. The introduction does not

acknowledge differences in power, history, and vulnerability between staff and service users. Brothers of Charity Services do not make a clear distinction between an allegation of abuse and a behavioural management issue. Some policies suggest the use of incident report forms, others suggest the template attached to specific abuse policies. There is confusion between incidents, allegation of abuse and complaints, this needs to be addressed and clarified to facilitate staff members in reporting.

Investigation of complaints or allegations of abuse have to follow two processes, firstly the investigation of the allegation and secondly the disciplinary procedures. Both processes are distinct but inter-related. The policy needs to outline how these two processes are to be coordinated. A client protection panel with managers from Human Resources and other relevant services could coordinate and oversee this area. A similar process is indicated where the complaint concerns a child and the investigation of the alleged abuse is carried out by the Gardaí and HSE in accordance with Children First.

Other relevant comments include:

- Some policies lack procedural attachments.
- Monitoring and checking of policy is not in place.
- Numbering of pages could be better. Some policies were not numbered.
- BOC logo not evident on every policy to convey importance and ownership.
- No review dates stated on some policies.
- Not clear who has overall responsibility in the organisation for the communication of the policies. This should be stipulated in each policy. Each policy should be accompanied by a clear implementation and monitoring plan.

## **Complaint/Incidents/Allegations 2004 – 2005**

### Areas examined

There are four main areas, which we examined:

- Complaints from whatever source made to Brother of Charity services Galway.
- Incident reports – Analysis of number of Incidents by Types and Challenging Behaviour Score.
- Allegations of Abuse against Service Users – all forms of abuse from whatever source.
- Allegations of Abuse against staff members.

### Comments Regarding Complaints

In accordance with the Brothers of Charity policy - *Complaint Procedure*, “A file of complaints shall be maintained in each service location using the Complaints Record form. The evaluation department will audit the complaints procedure in every team as part of the regular team review and will establish whether there are any trends in the types of issues raised. The evaluation department will produce an annual report to be considered by the evaluation sub committee”.

A copy of the annual report was requested for the years 2004/2005 but this process though outlined in the *Complaint Procedure* has not been implemented to date.

A very informative information leaflet produced by the Brothers of Charity Galway Services “*Guidelines for Service Users and Families who may have Concerns or Complaints*” is in place. This information leaflet is not routinely circulated or communicated to staff, service users, family members etc.

The information leaflet also states that “The Brothers of Charity Regional Council, which is composed of representatives of service users, family members, staff, management and the local community, will review all written complaints periodically in order to ensure that the services are dealing appropriately with service users and family complaints. The Regional Council will monitor all complaints to ensure that

the service learns from complaints, to the benefit of other families and service users”. On enquiry, the Regional Council has not reviewed any complaints to date.

A general list of complaints for 2004 and 2005 was requested. Incident reports, HR files for complaints against staff members, and designated files for allegations of sexual abuse were provided (which are commented on in this report). There were no other complaints made available. In all the documentation forwarded for the purpose of the review there was no evidence of a Complaints Record as indicated by the Brothers of Charity Galway Services *Complaints Procedure*.

### Incident Reports

Prior to 2005 incident reports were produced manually. In 2005 the Brothers of Charity Services Galway introduced a computer-based system to track the behaviour of service users. This was a proactive step to ensure that information was more accessible leading to more specific pattern identification to aid care planning. The information provided contained details ranging from minor behaviour to accounts of serious assaults by service user to other service user and to staff. An incident report form is completed for each incident and then logged into the computer database. The information can be assessed under a multitude of fields such as location, severity, type of incident, instigator and victim etc.

The system is structured for 9 categories:

**Table 8 Categories of Incident Report Forms**

<b>Category</b>	<b>Description</b>
0	None
1	Service User Self injury
2	Service User to Service User
3	Service User to Staff
4	Service User to Public
5	Service User Aggressive Behaviour
6	Service User Accident
7	Staff Accident

8	Member of Public Accident
9	Drug Admin Error

There are 5 levels of severity<sup>4</sup>.

**Table 9 Level and description of severity**

<b>Level</b>	<b>Description</b>
0	Don't Know
1	Minor
2.	Minor Moderate
3.	Moderate
4.	Moderate Severe
5.	Severe

It was intended to examine all incident reports for 2004 and 2005 but when the documentation was received there were approximately 2,000 incidents for 2005 and the computerised system did not cover 2004. It was decided therefore to limit the review to the 2005 figures. For the purposes of the review, the three highest categories, Service User to Service User (Category 2), Service User to Staff (Category 3) and Service User Aggressive Behaviour (Category 5) were selected.

In line with the service structure the figures were broken down into:

- East Galway Services
- West Galway Services
- Children Services

The figures for West Galway did not include the 4<sup>th</sup> Quarter for 2005.

In 2005 there were 908 incidents recorded in the East Galway Sector. 60 service users were identified as 'perpetrators' and of these 23 have just one incident in a year. There are 20 with 10 or more incident sheets usually in the more severe categories. Victims and locations were also identified.

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<sup>4</sup> A blank sample copy of an incident sheet is attached in appendix H

**Table 10 Incident Reports for East Galway 2005**

Category	Don't Know	Minor	Minor Mod	Moderate	Mod Severe	Severe	Total
<b>0 None</b>	0	2	1	0	2	0	5
<b>1 Service User Self injury</b>	1	1	5	18	12	3	40
<b>2 Service User to Service User</b>	1	14	29	79	77	21	221
<b>3 Service User to Staff</b>	2	6	25	42	98	15	188
<b>4 Service User to Public</b>	0	0	1	8	2	1	12
<b>5 Service User Aggressive Behaviour</b>	3	9	20	74	74	25	205
<b>6 Service User Accident</b>	3	48	39	33	43	0	166
<b>7 Staff Accident</b>	0	3	3	0	13	0	19
<b>8 Member of Public Accident</b>	0	0	0	0	0	1	1
<b>9 Drug Admin Error</b>	4	1	2	25	18	1	51
<b>Total</b>	14	84	125	279	339	67	908

**Table 11 Incident Reports for West Galway Jan – Sept 2005**

Category	Don't Know	Minor	Minor Mod	Moderate	Mod Severe	Severe	Total
<b>0 None</b>	1	1	2	0	0	1	5
<b>1 Service User Self injury</b>	7	2	15	27	21	6	78
<b>2 Service User to Service User</b>	9	20	38	64	50	20	201
<b>3 Service User to Staff</b>	4	19	28	72	63	88	274
<b>4 Service User to Public</b>	0	0	2	0	9	2	13
<b>5 Service User Aggressive Behaviour</b>	30	6	20	43	23	19	141
<b>6 Service User Accident</b>	44	28	23	9	7	0	111
<b>7 Staff Accident</b>	6	1	0	4	0	0	11
<b>8 Member of Public Accident</b>	0	0	0	0	0	0	0
<b>9 Drug Admin Error</b>	0	0	0	2	0	0	2
<b>Total</b>	101	77	128	221	173	136	836

**Table 12 Incident Reports for Children’s Services 2005**

<b>Category</b>	<b>Don’t Know</b>	<b>Minor</b>	<b>Minor Mod</b>	<b>Moderate</b>	<b>Mod Severe</b>	<b>Severe</b>	<b>Total</b>
<b>0 None</b>	0	0	0	0	0	0	0
<b>1 Service User Self injury</b>	0	0	0	1	0	0	1
<b>2 Service User to Service User</b>	4	0	2	10	5	12	33
<b>3 Service User to Staff</b>	3	0	5	24	36	44	112
<b>4 Service User to Public</b>	0	0	1	0	0	0	1
<b>5 Service User Aggressive Behaviour</b>	0	0	0	1	1	2	4
<b>6 Service User Accident</b>	30	0	0	0	0	0	30
<b>7 Staff Accident</b>	15	0	0	1	0	0	16
<b>8 Member of Public Accident</b>	0	0	0	0	0	0	0
<b>9 Drug Admin Error</b>	0	0	0	0	0	0	0
<b>Total</b>	52	0	8	37	42	58	197

This gave a total for the year (excluding three months from West Galway) of 1941 or an annualised figure of approximately 2158. While this appears to be a large amount of reports it must be remembered that this system is relatively new and it is a considerable challenge to ensure consistency of recording. The service are aware of a number of anomalies in the system and are currently reviewing the report forms specifically in relation to the categories and the information required. Some of the anomalies include the recording by some staff of service user self injurious behaviour as 20 incidents at level one and by other staff as one incident at level 5. BoC stated that ongoing training is mandatory for all front line staff working this system.

The reviewers were informed that there was a large reduction of the most serious behaviours between 2004 and 2005 prompted by the collection of the data. This is precisely the purpose of the system and promotes a proactive approach to safety of service users.

Brothers of Charity Galway Services management asked the reviewers to take the following into account; “We are conscious that the collection of such a large amount

of information can be perceived as reflecting a significant level of abusive behaviour. However a more accurate reflection would be to acknowledge that the detailed information which we have gathered enhances our ability to recognise where practices are less than satisfactory and allows us to identify vulnerable people and take the necessary steps to improve their safety. We have evidence that the level of negative incidents has reduced significantly as we have implemented strategies in the light of the knowledge obtained through this system.”

Review of Incident forms for 15 service users

Incident forms for 15 service users who showed highly in the above categories were examined individually. Six adults from Galway East and Galway West sectors and three from Children’s Services were chosen.

**Table 13 Examination of Incident Reports for 6 Service Users in East Galway Services**

Note S/U =Service User and N = Number of incidents levels of severity 4 and 5

	S/U A N = 6	S/U B N = 7	S/U C N = 9	S/U D N = 6	S/U E N = 21	S/U F N = 16	Total
Signed by Area Manager	0	0	6	0	0	2	8
Not Signed by Area Manager	6	7	3	6	21	14	57
Response <sup>5</sup> by Area Manager	0	0	1	0	0	0	1
Signed by Sector Manager	0	0	8	0	0	0	8
Not Signed by Sector Manager	6	7	1	6	21	16	57
Response by Sector Manager	0	0	2	0	0	0	2

<sup>5</sup> Response included Date of review, recommendations or plan.

**Table 14 Examination of Incident Reports for 6 Service Users in West Galway Services**

	S/U A N =21	S/U B N = 32	S/U C N = 19	S/U D N = 15	S/U E N = 12	S/U F N = 92	Total 191
Signed by Area Manager	0	0	1	0	8 <sup>6</sup>	0	9
Not Signed by Area Manager	21	32	18	15	4	92 <sup>7</sup>	182
Response <sup>8</sup> by Area Manager	0	0	0	0	8	0	8
Signed by Sector Manager	0	0	0	0	0	0	0
Not Signed by Sector Manager	21	32	19	15	12	92	191
Response by Sector Manager	0	0	0	0	0	0	0

In accordance with the policy on the *Reporting and Management of Incidents and Accidents* under the section ‘Incident Management and Reporting’, it stated that all accidents and injuries would be recorded and monitored, treated as important and reviewed by the appropriate manager.

In both East and West Galway Services a significant number of reports were not scored and reviewed as per the requirements of Brothers of Charity Galway Services’ policy as outlined above. In the reports examined the majority of incidents were not reviewed by the sector manager as required by the policy. There was little evidence on the report forms of the liaison between the area manager and the sector manager to establish and agree what actions were necessary to appropriately manage such difficult behaviour.

In the children’s service, incident sheets for three children were reviewed. There were 68 sheets in levels 4 and 5, approximately one third of the total.

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<sup>6</sup> This form was signed by the same person who signed as team leader so we are inclined to view it as an error.

<sup>7</sup> Three of these were not signed by a team leader.

**Table 15 Examination of Incident Reports for 3 Service Users in Children’s Services**

	Child A N = 27	Child B N = 13	Child C N = 28	Total 68
Signed by Area Manager <sup>9</sup>	N/a	N/a	N/a	N/a
Not Signed by Area Manager	N/a	N/a	N/a	N/a
Response by Area manager	N/a	N/a	N/a	N/a
Signed by Sector Manager	26	13	28	67
Not Signed by Sector Manager	0	0	0	0
Response by Sector Manager	3	1	10	14

*Comments regarding incident /accident reports*

The analysis of behavioural patterns provides a richness of information, which can track problematic behaviour, identify particular service users both as aggressors and victims and provide evidence of effectiveness of behavioural treatment programmes.

In accordance with the policy on the *Reporting and Management of Incidents and Accidents* under the section Incident Management and Reporting, it stated that all accidents and injuries would be recorded and monitored, treated as important and reviewed by the appropriate manager.

In both East and West Galway Services a significant number of reports were not scored and reviewed as per the requirements of Brothers of Charity Galway Services’ policy as outlined above. In the reports examined the majority of incidents were not reviewed by the sector manager as required by the policy. There was little evidence of the liaison between the area manager and the sector manager to establish and agree what actions were necessary to appropriately manage such difficult behaviour.

This pattern is different in children’s services where the sector manager signed all children’s forms and there was a response in a quarter of the reports. In all cases the incident sheet was completed with a large amount of detail and was duly signed by front line staff and their direct line manager.

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<sup>8</sup> Response included Date of review, recommendations of plan.

On review of documentation in both the adult and children's services it is not clear what action plans if any were developed and implemented.

As a result of feedback from the BoC services the reviewers were informed that there was clear evidence on main client files of effective liaison between the sector managers and the services senior management and with the area managers and other line managers. It was stated by BoC services that there were two fora for this: (a) a standing item on the Galway Services Management team agenda and (b) Sector Team Meetings. BoC services have ongoing behaviour strategy meetings and following the occurrence of a serious incident or assault, a 48-hour reactive strategy meeting would be organised and attended by the sector manager, multidisciplinary team, other staff and relevant family members. Minutes of these meetings are kept on the main file and are reviewed on a regular basis. Reactive strategy meetings include immediate action, medium term plans and identification of supports required for the service user's family and staff. In some cases these have led to expensive wraparound service.

The reviewers initial comments were perceived as unfair and not borne out by all the documentation. As a result of this the reviewers decided to examine a sample of case files.

#### *Outcome of review of files*

As part of the above process five of the above case files were reviewed on a random basis. The identified files included four from adult services (two from each sector) and one children's file.

Two of the files reviewed consisted of a small amount of information and begged the question were these complete case files. In three other files there was considerable information. There was no evidence of case conferences in three of the files. It was noted that one file contained evidence of regular review which was characterised by regular meetings with titles such as; case conference, case review, designated conference, behavioural support review and mental health clinic. In this case the

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<sup>9</sup> Unlike the Adult services there is Area Manager in Children's Services so this part of the incident.

involvement of the sector manager was unclear. While attendance at meetings was noted, the titles of staff were not noted. Rather than confirming the response of the Brothers of Charity management to the draft the 5 files examined did not demonstrate consistency with policy. It was not possible to check if meetings were held within 48 hours partly because many of the incident sheets were not scored in terms of seriousness. In the one case where there were regular meetings references to incidents were vague. It was difficult to track decision making. In the one case with regular review it was still difficult to understand how decisions were made e.g. to move residence and even more difficult to understand who had the lead role for ensuring that plans made for the service user were carried out.

A more detailed analysis of the incident report forms would have been envisaged and a more detailed proactive guidance to staff was anticipated. At the very least a printout analysis of the incidence reporting format should be contained within each file. It would be important for management to critically examine the same files and to establish for themselves the accuracy of our findings.

There are concerns about the child's file examined. In 2002 and 2003 there was good evidence to suggest that an issue of assault by another resident was subject to regular review including child protection conferences. It was of concern to discover that while there were fifteen incident reports in 2005 (most of them either 4/5 on the scale) there was no evidence of meetings, assessment of risk or a protection plan. There was one incident report of January giving details of the child being hit by the same service user that was involved in 2003.

#### Allegations of Abuse against Service Users (Designated Files)

Two lists relating to 2004 and 2005 were provided. The 2004 list is titled "Designated Referral List 2004" and summarises 21 referrals. The 2005 list is titled "Referral of Incident of Sexual Abuse and Follow up" and contains 28 referrals, which were broken down under the following headings:

#### **Table 15 Allegations of Abuse 2004 and 2005**

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form is irrelevant to children's services

<b>Referral by Category</b>	<b>2004</b>	<b>2005</b>	<b>Total</b>
Vague referral – unsure of nature of referral	3	1	4
Referral of direct Sexual Abuse	10	20	30
Referral of inappropriate behaviour (may not be abuse)	6	4	10
Referral which was not abuse (may be concern)	2	3	5
<b>Totals</b>	<b>21</b>	<b>28</b>	<b>49</b>

Table 16 documents the breakdown of alleged perpetrator or source of abuse in the 30 cases of direct abuse (10 from 2004 and 20 from 2005).

**Table 16 Alleged Perpetrator of Direct abuse referrals 2004 and 2005**

<b>Alleged Perpetrator</b>	<b>2004</b>	<b>2005</b>	<b>Total</b>
Current Allegations against family or public.	1	2	3
Current allegations against staff.	0	1	1
Current allegations against Service User.	5	4	9
Past allegations against family or public.	0	1	1
Past allegations against staff.	2	3	5
Past allegations against service users.	1	9	10
Unknown/unclear.	1	0	1
<b>Total</b>	<b>10</b>	<b>20</b>	<b>30</b>

The designated files of nine of the direct referrals of abuse, (three from 2004 and six from 2005) were requested and received to examine the processes involved in the Brother of Charity Services Galway when an allegation is made.

#### Comments regarding Selected Designated Files

##### File 1

There was a clear complaint or concern. An investigative interview was held and there were notes on the file. There were no conclusions and it was difficult to follow the decision making process. It was not clear if there was a corresponding staff file and what happened in relation to the staff member. There was no evidence of a strategy meeting or case conferences and there were no plans put in place.

#### File 2

There was no designated report in the file. There was evidence of an investigative interview. The matter was referred to the Gardaí. The outcome of the report was not clear and there was no documentation of a decision. There was no reference to a strategy meeting or a case conference.

#### File 3

There was no designated report on file. An investigative interview took place. The outcome of the investigation was unclear. On this file there were different reports and concerns about the service user's own behaviour. It was very difficult to follow. The Gardaí were informed and there was a referral to the Special Residential Redress Board. There was no evidence of a strategy meeting or case conference.

#### File 4

This was an unusual referral based on a report by a member of the public. There was no designated report. There was a clear outcome but no strategy meeting or case conference.

#### File 5

There was no designated referral, on this file but there was a report/referral form. It was believed that the information contained in this file did not constitute an allegation of abuse. There was some screening, an investigative interview but no evidence of an outcome or a strategy meeting or case conference.

#### File 6

There was a copy of the behaviour incident form on file but no designated referral form. There was evidence of a case conference yet the plan put in place was about the victim. There was a delay in notifying the Gardaí, which was revised on the 14/02/05 and not done until 19/07/05.

#### File 7

No evidence of a strategy meeting, case conference and no clear outline of sector manager's role. There was evidence of a lot of correspondence (in particular telephone calls) with the Gardaí requesting their assistance.

File 8

There was no clear process of investigation outlined. There was mention of a strategy meeting. No clear outcome for service user in the file.

File 9

No clear process outlined. Preliminary assessment could have been more clearly outlined. The outcome was documented.

It is clear from the review of the designated files that the Brothers of Charity Services Galway policy document "*Guidelines for the Investigation and the Protection of Adults and Children with a Learning Disability from Sexual Abuse in the Brothers of Charity Galway Services*" has not been completely adopted at operational level.

An analysis of the designated files demonstrates the wide variety of referrals. Approximately one third do not contain a clear allegation of sexual abuse. Some of the files concentrate on victims, alleged perpetrator or both. As commented elsewhere in the review there needs to be agreement within The Brothers of Charity as how to view service users who have inappropriate and non consensual sexual contact with others (usually other service users). Many of these service users are not capable of criminal responsibility and it may be more beneficial to treat their behaviour as a behavioural management issue. Where service users are capable of a level of responsibility they should be subject to the rigours of the legal process. Victims of abuse may have the same feelings of abuse regardless of the capacity or intention of the instigator. The investigation of the incident from the victim's perspective should be the main focus of the designated files. Did the incident take place and if so what services and protection plan does the victim need. If a protection plan is needed the person causing the harm should also be subject of a management plan for their behaviour.

Allegations against members of staff are because of the issues of power and responsibility needs to be managed differently. A parallel investigation of the concerns of the victim and a disciplinary procedure are needed. Service users who are victims of abuse from members of the public also require a different response. It is recommended that some clarification on the above issues be undertaken in order to provide the best response. It must also be stated that unlike the law as it relates to

children there is no similar civil law in relation to the protection of vulnerable adults. This places an organisation such as the Brothers of Charity at considerable disadvantage in trying to protect its service users. It is hoped that national guidance will be issued in the near future.

It was pointed out by the Brothers of Charity that the designated files do not contain all the information and that comments on the lack of outcome evident from the designated files may be unfair and inaccurate. Most of the information on follow up should be on the case file, including care review and case conference notes. Consequently two case files were examined in detail – File 6 and File 7, which contained details of three reports.

In File 6 there was no standard reporting form. There was reference to a case conference but this was held for the alleged abuser. There was no evidence of a client protection strategy meeting. There was a designated review meeting held on the 18/11/04, 09/12/04 and 14/02/05. An incident report form dated 07/05/04 did not lead to any investigation. There was reference to a similar incident of fondling on 15/05/04. It was not clear how this was followed up. There was some evidence of sector management involvement and the only client protection strategy seemed to relate to increase in staffing. It was very difficult to see how the concerns were assessed and concluded.

In file 7 a service user made allegations of hitting and fondling by her father. Front line staff and the social worker followed up the allegations promptly. The service user was interviewed and her mother contacted. The allegations were denied by the service users mother. There was no standard reporting form completed and no evidence that the sector manager received the information. There was no client protection strategy, no risk assessment and no case conference.

It was apparent for the review of the files that the terminology outlined in policy documents was not applied in practice. Rather than offering reassurance the examination of the case files caused more concern. It would seem that there is a gap between policy and practice and between practice and management expectations. Again it is recommended that senior managers examine these files for themselves so

that there is acceptance of the failure to achieve the organisations own standards of client protection.

Allegations against staff - HR records

For 2004 and 2005 there were 12 allegations made against 10 staff.

**Table 17 Allegations against Staff 2004 and 2005**

<b>Nature of allegation/complaint</b>	<b>Number</b>
Taking alcohol on duty	2
Service User left alone	2
Asleep on Duty	2
Stealing of Service User Funds	2
Past Abuse	1
Inappropriate language used to service user	1
Aggression towards Service User	2
<b>Total</b>	<b>12</b>

*Comments regarding Allegations against Staff:*

The HR Department provided the files in relation to the above allegations. In general there was evidence that all the allegations were investigated thoroughly. An investigation team of one current staff and one outside Consultant was set up. The team interviewed staff, service users and witnesses and produced a report with clear conclusions. There were clear terms of reference.

In the files provided there was no reference to the initial concerns or the decision-making processes to set up the investigation team. There was also no reference to the disciplinary outcome of the investigation. A separate corresponding form outlining the outcome was provided, which varied from no disciplinary action to verbal and final written warnings, and as far as dismissal. In line with the “*Guidelines for the Investigation of Complaints against staff members of Incidents of Abuse*”, the HR files should contain the process outlined in the policy from the making of a complaint to the final determination.

It was noted that although there were designated files pertaining to three staff members, there were no corresponding HR files. This was due to two of the allegations being currently addressed under Redress and one of the allegations following the preliminary assessment not requiring further investigation and closed out. BoC services informed the reviewers that in the case of past abuse a current internal investigation might not have taken place. It was suggested to the Brothers of Charity Services that practice should be reviewed to ensure that there is a proper record of how the allegation was investigated and documentary evidence of decisions made. There should be a record of the interview with the alleged victim and a plan of support if abuse has been validated. It is accepted that the alleged abuser's file is not the most suitable place to hold information about victims and the HR file should contain a summary of the allegations and cross reference to information confidential to the alleged victim.

The reviewers were informed that the above table contains all the complaints against staff. In relation to complaints against staff who are no longer employed it was stated that HR 'cannot conduct a HR investigation against a staff member who has left the service'.

Some other comments include:

- The interviews/ investigations were of a high standard and well recorded.
- The Role of the Gardaí in the investigation process was not very clear; files demonstrated a lot of contact through telephone calls rather than formal methods of communication such as an agreed template.
- The Role of the statutory body requires clarity, as there was no evidence of formal communication with the HSE in the files.
- A lot of information in the files was duplicated in other files.

### **Other Relevant Developments**

During this phase of the review we were given access to a number of reports and initiatives relevant to the protection of service users. These are summarised in this section.

#### Training and Communication

In 1999 Ms. Margaret Kennedy, a well known practitioner in the area of abuse against people with disabilities was engaged by the Brothers of Charity Services to provide training courses in client protection for the staff employed at the Brothers of Charity Galway Services. Ms. Kennedy ran 21 courses between 1999 and 2003, which were attended by 450 staff. Ms. Kennedy wrote a progress report pertaining to client protection for the Brothers of Charity. This report consisted of two parts. Part one was titled "*The development of a training programme*" and Part two was titled "*Useful Lessons for the Brothers of Charity derived from participants and trainer observation*". Part two of the progress report contained many serious criticisms of staff, systems and management regarding client protection.

Prior to forwarding the progress report to management at the Brothers of Charity Services Galway, Ms. Kennedy wrote to the Minister for Health and Children and the Irish Times detailing her concerns as highlighted in her progress report. Management at the Brothers of Charity Services confirmed that Ms. Kennedy did not inform them of her concerns or request a meeting to discuss them at any time. For the purposes of this review the Brothers of Charity Services were requested to comment on Ms. Kennedy's report. Their response is attached as appendix I to this document. The Brothers of Charity Services took the decision not to reengage Ms Kennedy, as a trainer from the end of 2003, following what they regarded was the unprofessional manner in dealing with her concerns.

Following the departure of Ms. Kennedy the course was modified and is now managed by the Social Work department. In 2005 four courses were provided for 70 attendees.

**Table 18 Number of Client Protection Courses 1999 - 2005**

<b>Year</b>	<b>Courses</b>	<b>No of staff attended</b>
1999	1	
2000	1	
2001	10	
2002	6	
2003	3	450
2004	0	
2005	4	70
<b>Total</b>	<b>25</b>	<b>520</b>

#### Client Protection Training Programme 2006/07

The current Client Protection Training Programme outlines a proposal for a substantial increase in the number of courses to a minimum of 9 in 2006 (up from 5 courses in 2005.) There are similar plans for 2007 with a recommended increase in trainers, which was identified by the Social Work and Training department. Four priorities in the area of client protection were identified:

- Ongoing training for new staff.
- Training for managers.
- Refresher training for long service staff members.
- Specific request for training in Kilcornan.

However, this plan will depend on the recruitment of 4-6 additional trainers.

#### Management of Serious Inappropriate Sexual Behaviour

A small number of service users were clearly identified as being responsible for serious inappropriate sexual behaviour on other service users (highlighted through the analysis of incident reports.) In response, the Brothers of Charity developed and implemented a 24-hour wraparound service for these service users with the objective of providing 'robust supervision' for the protection of other service users. Some of the plans involved the move from group living to more appropriate accommodation. This reduced substantially the number of serious assaults and was a major benefit to the safety of other services users. Legal advice was sought regarding the 24 hr supervision of clients and correspondence from BoC's solicitor pertaining to 24 hr service for one particular client was made available for the purpose of the review.

Legal opinion stated that although there is a clear breach of the specific client's personal rights to freedom which are of concern, it must be balanced against the care and security of other service users and that the actions taken by Brothers of Charity Services as regards the monitoring and isolation of the client was warranted and justified in all circumstances.

### Redress Board

Funding of 90K per annum for a period of three years was provided by the provincial superior to set up a team to assist and support service users who had been or may have been abused in the past and to provide them with appropriate services e.g. counselling, access to the Redress Board.

On the 07/11/04 Holy Family School and Kilcornan Services were named as qualifying services under the Redress Board. Brothers of Charity Galway Services were the only Intellectual Disability services, which applied for recognition under Redress and met with the Board to make representations on behalf of their service users. This development coincided with the recruitment of the team and it was decided to prioritise the applications for Redress due to the proximity of the closing date for application to the Redress Board – 15 December 2005. Brothers of Charity unsuccessfully requested an extension to this date.

The team identified 800 past and current service users, who may be eligible to apply to the Redress Board. This included:

- People in current Brothers of Charity Services.
- People in other services.
- People in no services.

Advertisements were placed in local papers, other disability services were contacted and 800 information packs were sent out. The pack contained information on redress and appropriate counselling and legal services. A major part of the work has been to engage and work with families on behalf of the service users. To date (April 2006) the BOC have received 119 applications for file information under FOI in connection with applications to the Redress Board. This figure is likely to increase.

Following this initiative, all adults currently in BoC services are being interviewed and screened to confirm if they had experienced any type of abuse while in receipt of Brothers of Charity Services. Counselling and psychological services are being made available where necessary. It was confirmed by Mr John Leinster that if an allegation of abuse were made then the Brothers of Charity would investigate the allegation as per policy regardless of abuse type or perpetrator.

This work is heavily influenced by a rights based perspective and the service sees itself as very proactive in this work. It is anticipated that this phase of work will be completed by June 2006. Phase 2 of this review will examine the process followed by the Brothers of Charity Services with regard to the above initiative.

### Brian McClean Report 2003

A report was commissioned by Mr Patrick McGinley, Director of Services to evaluate the challenging behaviour services in Kilcornan. Serious concerns were raised in the report on the safety and quality of care of the residents. The main findings of the report were as follows:

1. Clients are not safer in Kilcornan than they would be in the community.
2. Basic needs are not met.
3. Quality of life is very poor compared with other people with severe intellectual disability.
4. Standards practices of residential service provision are not in place.
5. Standards therapeutic processes have not been implemented.
6. Standard behaviour processes have not been implemented.
7. Families do not receive information required to protect their family members.
8. Basic maintenance tasks not carried out.
9. Basic management practices do not occur.
10. Staff rota is staff and not client centred.
11. There is a marked absence of accountability.
12. Recommendations from previous reports on Kilcornan (1984) have not been implemented.

A self-advocate group (service users) from Roscommon highlighted in the report the following main issues for residents:

- Lack of safety.
- Service users did not have the same opportunity to go to pubs and restaurants.
- Poor and basic maintenance.
- Service users got very little money.
- Everything was locked and kept indoors.

Mr McClean made a number of recommendations. An update on the implementation of the recommendations was requested from the Brothers of Charity Services. Mr Broderick, Team Leader, submitted a response<sup>10</sup> to the request which outlined some improvements under the following headings: Safety, Training, Advocacy Day Activities, Team Structures, Behaviour Support, Risk Funded Services, Community Developments, Assault at Work and Future Developments.

Mr McClean's main recommendation concerned the transfer of residents from Kilcornan to community-based services. Whilst there has been some development in this area as outlined by Mr Broderick in his response, the majority of service users have not to date been moved to community based services.

In the interest of progressing future service developments at Kilcornan, it was agreed by the management of the Brothers of Charity Services and the trade unions to commission an independent assessment of Kilcornan Services.

This assessment was contracted to an English company, 1066 Consultancy and Healthcare Consultancy Ltd and is currently in progress and will be completed by June 2006. All staff, service users, family and advocates are invited to participate in this assessment. It is envisaged by the Brothers of Charity Services that this process will provide a framework for future service developments and that the recommendations of this company will provide a basis for constructive negotiations to take place between Management and the Trade Unions.

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<sup>10</sup> The full response is included in Appendix J

### Personal Outcomes

Personal outcome evaluation model was established in 2002 and every adult service user has a personal outcome folder. It was reviewed in February 2006.

A copy of Personal Outcome Measures - Measuring Personal Quality of Life, 2005 edition was forwarded for the reviewer's attention by the Brothers of Charity Services Galway. The following is an extract from that document "The Personal Outcome Measures are a powerful tool for evaluating personal quality of life and the degree to which organisations individualise supports to facilitate outcomes. People define outcomes for themselves. The outcomes are non prescriptive, they have no "norms". Personal Outcomes are important because they put listening to and learning from the person at the centre of organisational life. Personal Outcome Measures enable us to learn about people in new and different ways. They provide a guide to person directed planning"

Within the Personal Outcomes Process each service user has an individual plan and if the service is not in a position to address the specific need after six months, a Barrier Form is submitted to the Sector Manager to highlight the outstanding needs. Reviewers were informed that in a number of cases an external consultant has been employed to carry out assessments.

The position of personal outcome processes in service user safety will be examined in detail in Phase Two of the review.

### Advocacy Working around Rights Training for Service Users

It is the key principle of the Brothers of Charity Services that people who use their services are involved in the local regional and national structures of the service. This principle is supported through the self-advocacy groups who meet at local, Regional and National level to discuss issues concerning them.

In the Brothers of Charity Services Galway there are a number of advocacy groups that meet on a regular basis in most of the centres. The purpose of the local groups is to empower people to speak up for themselves, develop their confidence and enable

them to get their voices heard so that they may have their opinions, needs, wants and desires taken into account in the planning and delivery of services.

The Brothers of Charity Services Galway hosted a service user conference in November 2005. The conference had as its theme “Rights and Responsibilities”. Guest speakers included Senator Maurice Manning of the Human Rights Commission and Michael Kendrick, a leading Consultant on including people with disabilities, in the decisions involved in providing services for them.

#### Service Users Council

A service user council was set up in 1996, which gives direct access on a quarterly basis to the Director of Services and Sector managers. The council has an annual meeting with the National Brothers of Charity Director. A full time advocacy worker supports the service user members of the council.

#### Relationship and Sexuality Training

Brothers of Charity services Galway provide extensive training for staff and many service users have participated in or are in the process of participation in relationship and sexuality training. BoC informed the reviewers that in research about to be published by the Irish Sex Education Network that 70% of organisations providing services to people with intellectual disabilities fail to provide any form of education around relationships and sexuality awareness.

## **Findings**

Outlined below are the main findings from the documentary review, which was undertaken between February and April 2006. Phase one (based primarily on documentation review).

1. There are a number of policies relevant to the protection of service users within the BoC services. Whilst many policies are very good in many aspects (e.g. definitions of abuse, recognition of abusive behaviour etc), it was clear from the examination of the core policies pertaining to abuse that they generally failed to outline the clear processes (steps) for the reporting and management of an allegation of abuse from its initiation to its actual closure (regardless of abuse type and identity of the perpetrator.) This was clearly reflected in the review of the designated files.
2. While it is not always possible to simplify complex issues there is a need to simplify and streamline the various protection policies. There is currently an overemphasis on sexual abuse and this should be rectified in future policy and procedural guidance. (See detailed comments in relation to policies - incident reports, allegations of abuse and complaints have been recorded under the appropriate heading in this document).
3. Documentation review demonstrated clearly that whilst there are numerous policies in place, some operational practices do not reflect what is indicated by the relevant policy, e.g. Complaints procedure, Incident reporting etc.
4. Brothers of Charity Services do not make a clear distinction between an allegation of abuse and a behavioural management issue. There is no clarity for staff for the reporting of same.
5. The Brothers of Charity Services are very clear on their reporting responsibility to the HSE when the client is a child, however the detail and the recording of initial concerns is not clear.

6. The Brothers of Charity Services Galway have no formal structure in place to inform the HSE of an internal investigation pertaining to an abuse allegation when the victim or perpetrator is an adult.
7. The Brothers of Charity Services Galway have no formal structure in place to inform the Gardaí of an internal investigation pertaining to an abuse allegation, when the victim or perpetrator is an adult. The policies contain no clear guidelines as to when Gardai should be notified.
8. BoC services have been proactive in client protection training and have full plans for the future.
9. The Brothers of Charity Services developed and implemented in March 2005, *A Personal Development, Relationship and Sexuality Education Programme for Adult Service Users*. This is a fifteen to twenty week programme and to date, ten courses have been successfully completed. Approximately 6 - 8 service users attend each course.
10. The database, developed and implemented by the Brothers of Charity for incident reporting, informs management on safety aspects and assists in the decision-making processes regarding the appropriate management of service users with severe abusive behaviour. It would be of interest to review in phase 2 of this report, the number of incidents associated with the 6 specific serious sexual abusers now in receipt of a 24 hr intensive service. A comparison of the number of incidents between the first 6 months of 2005 and that of 2006 should be made to ascertain whether the number of incidents has lessened as planned.
11. BoC commissioned Dr Brian McClean to carry out an evaluation of services in Kilcornan, which highlighted a number of serious concerns regarding service provision. To progress the main recommendation of this evaluation (the transfer of service users to community based services) the Brothers of Charity engaged a Consultancy Healthcare Group to carry out an independent assessment of Kilcornan Services, and make recommendations (to be

completed by June 2006) that will provide the basis for constructive negotiations to take place between management and Trade Unions.

12. Funding of 90K per annum for a period of three years was provided by the provincial superior to set up a team to ascertain the number of service users who had been abused in the past and to provide them with appropriate services. Currently all service users in residential care or who have been in residential care in the past are being screened regarding abuse.
13. Brothers of Charity Galway Services were proactive in making representations to be included in the Redress Scheme.
14. Brothers of Charity have implemented a personal outcome model of service for all adult service users. A similar scheme for children will be completed in the near future. The model of service is client focused and person centred and its implementation commenced in 2002.
15. A self-advocacy service was set up as a platform for service users to express their views and concerns.

There is a genuine commitment within BoC to safeguard service users as demonstrated through the variety of policies available. It is difficult to ascertain how well the client protection policies have been implemented in practice and this will be examined in phase two of the report.

The reviewers wish to thank the Brothers of Charity services for their assistance with phase one of the review, and in particular Mr John Leinster for his prompt response to the many requests for information.

## **Appendices**

### **List of Appendices**

**Appendix A Analysis of staff 2004**

**Appendix B Staff Occupational Category 2004**

**Appendix C East Galway Adult Services**

**Appendix D West Galway Adult Services**

**Appendix E Children's Services**

**Appendix F Template for Policy Formulation**

**Appendix G Comments on Core and Related Policies**

**Appendix H Copy of Incident Report Sheet & Guidance**

**Appendix I Response to Margaret Kennedy's Report**

**Appendix J Update progress on Dr. McClean's Report**