Chapter 1

Background

Taking Stock

An investigation by the Ombudsman into complaint handling and issues identified in complaints made about the Child and Family Agency (Tusla)
An investigation by the Ombudsman into complaint handling and issues identified in complaints made about the Child and Family Agency (Tusla)

(Under Section 4 of the Ombudsman Act 1980, as amended)

July 2017
Foreword

Protecting children is a key duty for the State. Tusla has the key role, alongside An Garda Síochána in doing so. Tusla also has important duties in other areas including fostering.

My role is to consider unresolved complaints against Tusla affecting adults and to make sure that they have been treated properly and fairly. The most frequent complaints arise from foster parents, applicants undergoing assessment for the foster parent role, adults who were allegedly abused during their childhood, and individuals currently accused of abuse.

In relation to individuals accused of abuse, the most common complaints that I have received related to the failure of Tusla to follow due process.

“Failure to apply natural justice and fair procedure can give those who pose a risk the opportunity to continue to abuse and those who are falsely accused can have their lives or careers ruined or, at least put on hold for long periods.”

In addressing allegations of abuse, the welfare of the child must be paramount. Accordingly, when allegations of abuse are notified to Tusla they need to be assessed urgently and effectively. This is essential in order to establish the credibility of the allegations at an early stage and to determine what risk mitigation measures, if any, might need to be put in place. A speedy response from Tusla is also essential to ensure that adults against whom allegations are made are treated fairly. If this is done as it should be, then allegations of abuse against adults, which are not upheld, will also be dealt with swiftly and effectively. To be falsely accused of abuse can have a devastating effect on the individual, and this places a clear onus on Tusla to follow due process to establish the facts and potential risk as quickly as possible.

When adults who claim to be victims of childhood abuse bring this to the attention of Tusla, they deserve to have their cases handled sensitively and effectively, to ensure that any current risk is managed.

In my 2014 Annual Report (page 20) I expressed my concerns about the handling of cases by social workers, particularly those involving historic allegations of abuse. I reported at the time that my Office was working with the then newly established Child and Family Agency, Tusla, in order to ensure that it put in place clear policies and procedures for the handling of such cases. The primary issues of concern included the need to follow fair procedures and natural justice and the need to carry out assessments in a timely, consistent, fair and thorough manner. The Barr and O’Neill judgments were also a factor in Tusla recognising the need for such policies and procedures.

Since then, my Office has continued to receive a variety of complaints in these areas, which again called into question whether the underlying concerns had been properly addressed. This prompted me to initiate this systemic investigation in June 2016.

The report is based around a number of themes which are illustrated by case examples. In preparing it, my Office drew on a sample of nine particularly challenging complaints covering the period 2012 - 2016, which we had either upheld or partially upheld, and 30 complaint files chosen at random from Tusla’s complaints system. While the volume of complaints to my Office is relatively low, nevertheless, the impact or adverse effect on the individuals concerned can be significant. Examples of good complaint handling within Tusla have also been referred to in this report.

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I should stress that at all times my Office received full co-operation from Tusla senior management and headquarters staff.

Complaints provide a valuable source of information for any organisation and it is important that they are embraced so that learning can be derived from them. The way they are handled reflects the culture within that organisation. It is essential that where complaints identify failings which are systemic, and by their nature likely to affect others, that there are systems in place to highlight the need for change. It is also important that there is awareness of these concerns at each level of management and at Board level, and that there are systematic approaches used to identify necessary changes, to make those changes and to monitor their implementation and ensure that the desired outcomes are achieved.

The consideration of the nine complaints considered in this report identified serious administrative shortcomings including the failure to follow due process, delays in dealing with concerns, in communication, in record keeping and in other areas. These are suggestive of a service which is over-stretched, which does not have appropriate processes in place in key areas, which can be inconsistent across the country and which has, in the past, been unable to respond with the necessary urgency to allegations of abuse. While Tusla now has a case prioritisation and case management system in place, it is important that these are quality audited to ensure that they are working effectively. I am aware that Tusla has undertaken a number of reviews as part of its quality assurance framework. It is, however, important that the implementation of all policies is subject to regular audit, including complaint handling, to ensure that the complaints process itself is being properly followed. Complaints about children fall properly within the jurisdiction of the Ombudsman for Children. However, I am concerned that the administrative failures we have identified, if not addressed, are likely to lead to failures in safeguarding the welfare of children at risk.

I welcome the recent investment by Tusla in additional social work staff. Well qualified, effectively led and managed, and properly trained social workers are at the heart of the service provided by Tusla. They need to have the time, training and support necessary to deal with the demands placed upon them. This is a vital area of work and places huge demand on those charged with it. Tusla has not up to now, had the level of resource that it requires to discharge its responsibilities.

The report makes a series of recommendations for improvement some of which Tusla has already started to implement. These recommendations have been considered by the management of Tusla, and reflect their views. I am pleased to say that Tusla has agreed to implement them and my Office will be closely monitoring their implementation.

Peter Tyndall
Ombudsman
July 2017
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Executive Summary

This investigation by the Office of the Ombudsman looks at how the Child and Family Agency (Tusla) handles complaints about the services it provides and at the issues, which form the subjects of these complaints. In particular, it looks at how Tusla has dealt with complaints about the management of retrospective allegations of child abuse, at how current allegations against adults are handled and at interactions between Tusla and foster carers. These represent the main subject areas of complaint about Tusla dealt with by the Ombudsman.

To put matters in context, Tusla received over 47,000 referrals to its Child Protection and Welfare Service in 2016. Some 20,127 (43%) of those referrals required an initial assessment. During the same period Tusla received 1,172 formal complaints, 54 of which ultimately reached the Ombudsman. In 2016, nine of those complaints were either upheld or partially upheld. While the Ombudsman acknowledges that the volume of social work related complaints made to his Office tends to be low, nevertheless many lessons can be learned from individual complaints.

This investigation looked at how nine particularly challenging complaints made to the Ombudsman between 2012 - 2016, which identified elements of poor administration, were handled. As part of the investigation, 30 complaint files internal to Tusla were also reviewed. In addition, the Ombudsman hosted a Workshop which was attended by 30 complaints officers working at a senior level across Tusla services, to explain his role and to listen to what they had to say about the complaints process.

Please note that the names of the complainants have been changed to protect their identities.

The key findings that emerged from this investigation are set out in this section along with the recommendations designed to address the failings.
1. Undue delay in dealing with allegations of abuse

**Findings**
- long delays in the allocation of cases involving allegations of abuse to social workers;
- long delays in contacting people who had made allegations;
- long delays before interviews commenced with the person subject to an allegation of abuse and in concluding assessments, and
- significant delays in responding to complainants.

**Recommendations**
- identify the necessary resource level to manage the current and expected caseload and ensure that sufficient qualified staff are recruited and in place to provide a timely service;
- ensure that electronic case management systems are in place and properly used to provide high quality management information so that trends are identified and managed;
- review case prioritisation to satisfy managers that the most urgent cases are dealt with expeditiously;
- properly resource the complaint function as dealt with below.

2. Right to fair procedures and due process

**Findings**
- in some instances, the subject of an allegation of abuse was not provided with details of the allegations made against them in writing;
- in some instances, the subject of an allegation of abuse was not advised they could bring a support person to interview;
- adequate notes were not taken during the interview process;
- notes taken were not shared with the person subject to an allegation of abuse for verification purposes;
- the name of the person who made anonymous allegations was withheld from the person subject to an allegation of abuse which is not in keeping with Tusla’s Policy and Procedures for Responding to Allegations of Abuse and Neglect (Tusla’s September 2014 Policy);
- the subject of an allegation of abuse was not given a copy of Tusla’s September 2014 Policy so that they could understand the process which lay ahead.

**Recommendations**
- finalise and publish Tusla’s September 2014 Policy by October 2017;
- provide training to all social work staff on the policy;
- regularly audit a sample of case files to ensure that the policy is being followed.
3. Notetaking and Record Keeping

Findings

- notes taken during interviews were shredded before their contents were verified with the person subject to an allegation of abuse;
- inadequate or inaccurate notes were taken during the interview process;
- Tusla’s September 2014 Policy was not followed which sets out how social work notes should be recorded and maintained.

Recommendations

- reinforce the requirements of good note keeping as part of the training package;
- where issues relate to individual practice, training and other learning and development responses such as mentoring, coaching and performance management should be considered;
- consider the introduction of audio recording to avoid disputes about the content of interviews;
- interview notes to be retained at least until a typed note of the interview is agreed with the person subject to an allegation of abuse. There are situations where the notes may never be agreed by attendees, in which circumstances, a record of the meeting with a note of the points of dispute should be retained.

4. Communication

Findings

- social workers in some cases did not demonstrate good communication techniques and appeared to lack empathy;
- counselling services and support should have been offered (as per National Standards) once the fostering placement ended in an unplanned way;
- confidential communications issued to an incorrect address on two occasions.

Recommendations

- each social worker should be required to ensure that they have up to date contact details for each open case and that these details are validated through supervision;
- the medium of communication (e.g. email only) should be agreed with the individual in advance;
- training should be provided to social workers where there is evidence through complaints or otherwise that communications have not been at the expected standard, to include Data Protection obligations or when the National Standards for Foster Care have been breached.
5. Support and training for staff

Findings

- Tusla’s Staff Supervision Policy was not properly implemented in light of the failure by staff in the case studies to follow Tusla’s Policy and Procedures for Responding to Allegations of Child Abuse and Neglect;
- delay in the provision of training for staff when new policies are introduced;
- no evidence to suggest that auditing is taking place with regard to the implementation of all Tusla policies.

Recommendations

- require Area Managers to document the action taken when shortcomings are identified and to record the outcome of such action;
- the annual training plan to include training for all staff on new policies which have been introduced;
- comprehensive case audits to take place to ensure that all policies are being followed and that the desired outcomes are being achieved. Any shortcomings identified to be addressed through ongoing reviews of policies and procedures, support for individual staff members and training programmes.

6. Management and recording of complaints and complaint handling

Findings

- complaints not dealt with in a timely way and complainants not updated in line with the relevant complaints policy;
- the tone of the response in some Complaints Officers’ reports was overly defensive;
- use of independent advocacy not considered to support complainants;
- mediation could have been used to resolve complaints in some instances to assist local/informal resolution;
- training in complaint handling not provided to Complaints Officers;
- no mechanism for Complaints Officers to share the learning from complaints;
- while staff were trained to use the National Incident Management System (NIMS) to record complaints, not all staff were actually using it;
- social work records not reviewed as part of the examination of some complaints;
- lengthy delays in assigning review officers to conduct reviews.
Recommendations

- all complaints to be properly recorded on the NIMS;
- the use of the NIMS to be evaluated to ensure that it is fit for purpose in respect of categorising complaints, managing complaints and identifying trends arising from complaints;
- dedicated Complaints Officers to be appointed across the regions and properly trained;
- quarterly casebooks to be prepared to share learning at local, regional and national level;
- managers at all levels and the Board to have clear visibility of complaint outcomes and to take responsibility for developing action plans and monitoring implementation and successful outcomes;
- consideration to be given to changing the complaints process to eliminate the review stage and encourage earlier access to the Ombudsman. This would require a statutory amendment. In the interim, the review stage should be properly resourced, and shortcomings identified in complaint handling at this stage be used as a source of learning;
- advocacy services should be made available to assist complainants as required;
- consideration should be given to the use of mediation to help resolve complaints locally in the first instance;
- consideration should be given to the development of easier access for individuals to complain (e.g. through electronic means such as the development of apps or through social media).

7. Signposting to the Ombudsman

Findings

- information about the right to seek a review following the examination of a complaint not provided in every case;
- significant number of complainants not advised of their right to make a complaint to the Ombudsman.

Recommendations

- all staff should be made aware of their obligation to comply with notification proceedings as set out in “Tell Us” (Tusla’s Complaints Policy) and to provide reasonable assistance to individuals as provided for under Section 4A of the Ombudsman (Amendment) Act 2012;
- the text for such notifications should be agreed with the Ombudsman’s Office.

The Ombudsman wishes to acknowledge that Tusla has already commenced implementation of some of these recommendations. However, he intends to ask Tusla to develop an action plan in order to monitor the implementation of them all. The Ombudsman will review outcomes within a specified timeframe.
Chapter 1

Undue delay in dealing with allegations of abuse
Undue delay in dealing with allegations of abuse

“All child protection and welfare concerns reported to [Tusla] must be acted upon immediately and formally recorded, and followed up as soon as possible”.


“This type of investigation is a most serious obligation that falls on the respondent. The safety of vulnerable children is at stake. Such an investigation should always occur at the earliest possible time after the risk to a vulnerable child is apprehended and before the risk crystallises into actual harm.”

*(MI v HSE [2010] IEHC 159, Hedigan J)*

From the perspective of alleged victims, persons subject to an allegation of abuse, and any other parties directly involved in such assessments, the consequences of delay can be far-reaching and profound. The assessment of historical allegations of abuse present their own unique challenges, which can be compounded where unacceptable delays occur in determining potential risk. With the passage of time, witnesses may be difficult to trace or may even be deceased. Evidence gathering becomes more problematic and people’s recollection of dates, times and events become less reliable.

Where criminal proceedings are initiated, a person subject to an allegation of abuse can seek to halt such proceedings before the courts on the basis that the passage of time makes a fair trial unlikely and makes it impossible for the person subject to an allegation of abuse to defend himself or herself properly. Following initial consideration of allegations, it is preferable to give an indicative timescale to the parties involved as to the likely length of the assessment process. This will avoid an undue expectation arising on the part of those involved as to the length of time it may take to arrive at an outcome. On occasion, for valid operational reasons, it may become clear that anticipated timescales cannot be met. In such cases, where practicable, the parties involved should be given an explanation of the difficulties and revised indicative timescales.

Lengthy delay can adversely affect the quality of an assessment process for a variety of reasons. Assigned caseworkers may leave and a case may have to be reallocated to someone else or to a succession of different caseworkers over time. Sometimes files have to be moved to another regional area for operational reasons. This leads to a fractured assessment process, a loss of corporate memory, and a lack of continuity and consistency. Evidence may have to be re-assessed or revisited and previous work duplicated. Crucial evidence may be missed, lost or misunderstood and the assessment pathway may change or be reversed.
The impact of this can be addressed through the recommendations made above concerning training of staff and data management. It is also noted that Tusla prioritises current cases of alleged abuse involving children and that the delays referred to in this report relate mainly to historical allegations made by adults.

At an organisational level, information on case times and case delays needs to be recorded and monitored and reported upon in a structured, frequent and consistent manner. Such information needs to be presented in such a manner that those with the authority at the top of the organisation have robust information available to them to make strategic decisions about the deployment of resources throughout the organisation. It should also enable them to identify bottlenecks to deal with them.

Proper investment in IT recording and reporting systems is key to providing management with the necessary tools to identify and tackle delayed cases. Line management at all levels need timely and accurate information on individual caseloads in their areas and the work performance of caseworkers. Comparative information on performance at individual, local and regional levels can also highlight high performing areas. Efficient and effective work practices, once identified, can be used in to improve performance in other areas, which are evidently less efficient.

In responding to a draft of this report, Tusla said that:-

“One of the most significant challenges facing Tusla since establishment has been the management of allegations of abuse, particularly those when an adult comes forward with an allegation of abuse which happened to them as a child. The State has unequivocal duties to children who are not receiving adequate care and protection. These obligations arise from the Constitution and have been placed on a statutory footing in the form of the “Child Care Act 1991”. The Act provides a legislative framework for best promoting the welfare of children and confers both statutory powers and duties upon Tusla. However, there is no specific provision within the Act to conduct assessments of abuse perpetrated against children and in the vacuum of a legislative provision, Tusla conducts its assessments in accordance with its policy, which is, in turn, informed and shaped by case law and best practice”.

It added that: -

“In conducting such assessments, the sole objective of Tusla is to identify, and thereafter manage, any risk posed to children. It is not the function of Tusla to detect and prosecute a criminal offence, to administrate justice or to make a finding of innocence or guilt. These are matters reserved for An Garda Síochána, the Director of Public Prosecutions and the Courts of Criminal Justice.

Furthermore, Tusla, unlike many other State entities, has no statutory powers to compel individuals to engage in a process of assessment or obtain relevant information from third parties such as schools, GPs, hospitals and the Gardaí. Fundamentally, there is an absence of statutory guidance and parameters for such investigations to ensure the constitutional rights of all parties are protected. In this regard, social workers often have to weigh up two conflicting but credible accounts of events. Sometimes people will refuse to engage in the process and third parties holding relevant information may decline to assist.

Therefore, in undertaking such assessments, Tusla must delicately balance Constitutional rights i.e. child’s right to be protected, cared for and their welfare safeguarded; and the accused person’s right to maintain their good name, family life and livelihood; all of which comes under scrutiny in
any assessment of allegations. Tusla must ensure that none of these rights is breached, while at all times remaining fair, impartial and objective.

The current legal framework with respect to managing allegations is inadequate and not equipped to meet both the needs of children and protect the rights of individuals against whom allegations have been made. It is in need of an urgent legislative overhaul. Tusla and its predecessor, the HSE, have long recognised the inherently flawed system in operation and have strongly advocated for an independent statutory body to conduct such investigations in order that there is no conflict of interest in the protection of children and fair and due process for the person against whom allegations have been made”.

Example 1

Five-year delay in finalising consideration of retrospective allegations

Mr & Mrs Lynch had supervised access to their grandchildren who were in long-term foster care. Two of their younger teenage children continued to live with them. The grandchildren’s mother, who was not living with her parents, made retrospective allegations of abuse against her father. Supervised home access visits, which had been approved in principle, were placed on hold pending the outcome of a credibility assessment by the HSE (subsequently Tusla). A credibility assessment is carried out to determine whether an allegation made is plausible and whether there is any potential risk to a child or children as a result.

In line with the Children First Guidelines, the Gardaí were notified of the allegations and they interviewed Mr Lynch. A file was sent to the DPP who determined that there was insufficient evidence to proceed with a criminal case. Notwithstanding this, the HSE indicated that it intended to complete what it termed an “internal investigation”.

Two years after the allegations were made, the HSE wrote to Mr Lynch to advise him that they were considered to be “inconclusive”. At that stage, the Children First Guidelines had been revised and “inconclusive” was no longer a valid outcome. No credibility assessment of the allegations had been undertaken by social workers and no risk assessment had been carried out in relation to Mr Lynch’s teenage children.

The Ombudsman became involved after TUSLA had taken over the child protection function. Tusla agreed to seek an independent assessment of risk. Mr Lynch’s health deteriorated and he was unable to participate in the assessment process. Following the Ombudsman’s intervention, however, Mr and Mrs Lynch were granted supervised access to their grandchildren in their home. He subsequently passed away.

Tusla ultimately concluded that the allegations were “unfounded”. This was more than five years after the retrospective allegations had been made.
Example 2

Fifteen month delay in follow up of retrospective allegations

Ms Flynn complained that when she made retrospective allegations in writing that a relative had abused her, they were misfiled. When the allegations had initially been received in the social work department they were discussed at a Child Protection Meeting. This meeting had been arranged to devise a strategy for examining the allegations. Afterwards, it was thought that the allegations had been forwarded to a named social worker to conduct an assessment as to their credibility.

Having heard nothing for four months Ms Flynn made a number of phone calls to the social work department, which were not returned. She wrote to the social work department but subsequent appointments to meet her were cancelled on three occasions at short notice. When the meeting eventually took place, she was told that her original statement had been misfiled. Ms Flynn provided the social workers with a copy of her original disclosure letter.

After the meeting, the social worker she had met wrote to her but sent the letter to the wrong address. Not having received the letter, she wrote to TUSLA Head Office. The person appointed to deal with her complaint wrote to her but again the letter was also sent to the wrong address.

Ultimately, one year after making her original disclosure an assigned social worker met with her in the company of her counsellor. At this meeting, the social worker did not take proper notes and subsequently contacted Ms Flynn’s counsellor to obtain contact details for children considered by Ms Flynn to be at risk. Because of the misfiling of the original allegations, the delay in assigning a social worker to the case, and the failure to record contact details for children considered potentially to be at risk, the follow up assessment of these allegations was delayed for over fifteen months.

Issues about undue delay were also uncovered in the examination of TUSLA’s internal complaint files as follows:

• two cases relating to the disclosure of retrospective allegations of abuse were not followed up over a three-year period. In one case, the complainant was advised that systems were getting better but that resource deficits had resulted in her case not being allocated. She was advised that specific teams had been put in place to address these types of cases. In the other case, by the time the assigned social worker made contact with the complainant, the person subject to an allegation of abuse had passed away;
• another disclosure of alleged historical abuse remained unallocated to a social worker for more than six months. The complaint related to the lack of contact from social workers both before and after the case had been allocated and the failure to update the complainant;
• there was lack of contact over a five-month period with a father who had reported alleged inappropriate sexual behaviour in relation to his children;
• another case highlighted that there was a lack of any contact or support from the assigned social worker in a relative foster care placement over a period of eight months;
• retrospective allegations of physical abuse made by a foster child against his former foster parents and ultimately deemed “unfounded” took eighteen months to bring to a conclusion;
• concerns about a foster child made by way of a phone call were left on a person’s desk but overlooked for seven months before being followed up;
• one complaint related to the making of approximately twenty-eight phone calls to the social work department only four of which had been returned. The complaint related to the social worker’s interaction with the complainant concerning access to his children following a marriage breakdown.

Findings

• long delays in the allocation of cases involving allegations of abuse to social workers;
• long delays in contacting people who had made allegations;
• long delays before interviews commenced with the person subject to an allegation of abuse and in concluding assessments; and
• significant delays in responding to complainants.

Recommendations

• identify the necessary resource level to manage the current and expected caseload and ensure that sufficient qualified staff are recruited and in place to provide a timely service;
• ensure that electronic case management systems are in place and properly used to provide high quality management information so that trends are identified and managed;
• review case prioritisation to satisfy managers that the most urgent cases are dealt with expeditiously;
• properly resource the complaint function as dealt with below.

In responding to a draft of this report, Tusla said that electronic case management systems have been put in place through NIMS (National Incident Management System) and further development is planned through the roll out of the National Child Care Information System (NCCIS) and Tusla’s ICT Strategy. Tusla also said that case prioritisation has already been completed under the Review of Retrospective Cases Awaiting Allocation undertaken by the Director of Quality Assurance and a service improvement plan developed.

I welcome these developments as they potentially represent a sound basis to build on the relevant recommendations in this report.
Chapter 2

Right to fair procedures and due process
Right to fair procedures and due process

Fairness and consistency is a key element to good administration. The complaints which the Ombudsman receives primarily relate to social workers not following fair procedure or natural justice in their interactions with the complainants who have been the subject of abuse allegations. In some instances, the complainants had not been given a written account of the allegations made against them, they were not allowed to have a support person attend with them when being interviewed, and information about the unproven allegations was disclosed to others without the complainant being afforded any avenue of appeal. While the protection of children must be a priority for social workers in accordance with their statutory role, adults against whom allegations have been made must be afforded due process.

Child Protection: Role of Tusla v An Garda Síochána

Tusla and An Garda Síochána are the key agencies empowered by law to carry out assessments and investigations of suspected child abuse and neglect. Each agency manages the responsibility within its brief and their joint efforts are designed to ensure that the protection of vulnerable children receives priority attention. An Garda Síochána has the additional responsibility of bringing allegations of abuse to the attention of the Director of Public Prosecutions (DPP) who decides on and carries out prosecutions. Even where the DPP finds insufficient evidence to proceed with a case, Tusla has a duty to assess and manage credible allegations.

Where Tusla suspects that a child has been or is being physically or sexually abused or wilfully neglected, An Garda Síochána must be formally notified in accordance with the procedure set out in Paragraph 7.4.5 of the Children First: National Guidance (2011).

The functions and roles of Tusla staff and An Garda Síochána are different. It is important that all personnel in both services work closely and collaboratively to secure the protection and welfare of children, which is of paramount importance.

Retrospective disclosures

It can be daunting for an individual to make a retrospective disclosure about childhood abuse. Sometimes it can take the individual many years before they feel able to tell anyone about what happened.
When a disclosure is made by an adult who suffered abuse during their childhood and it comes to the attention of either Tusla, An Garda Síochána or another service, the current risk to any child who may be in contact with the person subject to an allegation of abuse must be established. This is in line with Children First; National Guidance 2011. Furthermore, if any potential risk is considered to exist, this information must be shared between both agencies, in line with the notification procedures. It is essential that all relevant information in relation to any of the above is carefully collated and that each agency informs the other of any such concerns during an investigation or assessment process.

**Due Process**

Due process must be afforded to any adult against whom an allegation has been made and social workers must demonstrate that they have applied it in practice. In general, this involves keeping an open mind and not making assumptions, sharing information openly and making sure a person subject to an allegation of abuse has an opportunity to comment on the accuracy of interview notes, and interviewing sources suggested by a person subject to an allegation of abuse. Social workers have a duty to protect unidentified children from potential abuse as well as identifiable children from a current risk of abuse. As previously mentioned, disclosures of historical abuse can be particularly problematic for social workers to deal with.

In September 2014, Tusla introduced a new policy document (Policy & Procedures for Responding to Allegations of Child Abuse & Neglect). This policy and the associated procedures have been developed to take account of two key court judgments known as the Barr and O’Neill judgments. Discussions had also been ongoing between Tusla and the Ombudsman’s Office following a series of complaints about unfair procedure.

The current investigation has revealed that the processes set out in the September 2014 Policy Document are not being adhered to on a national basis.

The reasons for this are complicated. The September 2014 Policy was made available to social workers through Tusla’s internal information hub. Tusla explained that on advancing implementation of the Policy, some significant questions arose which required some minor amendment and additional practice guidance and training. A Review Group was appointed to address operational challenges with consistent implementation and significant legal cases relating to the application of fair procedure in such cases. In this context, the Ombudsman’s request to part-publish the policy document was not considered feasible.

The Review group finalised its work in March 2016. Training for staff was to commence across the service. However, there were two legal judgements awaited which it was felt might affect specific aspects of the Policy. As a result, Tusla said the Policy was removed from the website to avoid confusion but the document still stood as agreed policy within the service. This was pending the Senior Management Team’s approval of any amendments. Tusla said that the Policy continued to be provided to people on request but that it would not be published until the legal judgements were available.

In recent correspondence with the Chief Executive with regard to the Policy, the Ombudsman was advised that:

- the Policy Document is undergoing final review at the request of the Chief Operations Officer and is due to be presented to the National Policy Oversight Committee in the coming weeks. Thereafter, it will issue to the system and it is intended that this will be completed by October 2017;
the implementation of the revised document will be the subject of a detailed plan which will include briefings and training for staff;

- a plan will also be devised to ensure effective implementation of the policy across the entirety of the operation system.

The current policy requires that any person against whom an allegation is made is provided with a copy of the policy. Complaints recently received by the Ombudsman suggest that this is not happening in all cases. For example, in the case of Mr Smith (Chapter on Right to Fair Procedure and Due Process) in responding to his request for guidelines about the investigation process Tusla gave him a copy of the Child Protection and Welfare Practice Handbook (2011) and not Tusla’s September 2014 Policy. Mr Smith only got a copy of the policy after he contacted the Ombudsman’s Office.

There are two significant judgments which significantly impact on Tusla’s child protection work. These are the Barr and O’Neill judgments which are summarised below and at Appendix 3.

**Barr judgment**

The Barr judgment was delivered in a case dating back to 1997, where a father of three against whom there were long-standing abuse allegations, enrolled in a childcare course, which involved a placement in a children’s play centre. When the health board learned of this, it contacted Dublin VEC, which then excluded him from the placement. The disclosure and the exclusion were upheld by the High Court as being in line with the health board’s duties. However, in his judgment, Mr Justice Barr set out a series of guidelines to assist in the conduct of investigations into child abuse allegations and ensure compliance with fair procedures. These included the following:

- before any approach was made to the school, the man should have been furnished with a list in short of the allegations;
- he should have been asked to respond thereto in writing or orally at a meeting;
- no decision should have been made about him until the applicant had been given a reasonable opportunity to make his defense to the charges against him;
- after that, the health board should carry out such further investigations as might appear appropriate in the light of information furnished by way of defence.

**O’Neill judgment**

This case involved a teacher in a secondary school, about whom the health board received information about potential sexual abuse of a pupil in November 2001. There were significant delays in notifying Gardaí and the accused and in providing full information to the school. The teacher was suspended but this was subsequently revoked. He declined to return to school while still under a cloud of suspicion. The health board was heavily criticised for its handling of the case, for poor investigative and collaborative processes, taking an approach that neither served to adequately protect children or to preserve the administrative rights of the teacher.

**Ombudsman complaints**

In some of the complaints examined by the Ombudsman, adults against whom allegations were made did not receive notice of the allegations before being interviewed by a social worker. Nor were they advised of their right to bring a support person to the interview. This was not in accordance with fair procedures as outlined by Justice Barr in 1997.
Tusla’s September 2014 Policy, which is referred to above states:

- that it is the right of a person subject to an allegation of abuse to know who has made the allegation;
- that anonymity cannot be guaranteed;
- that it is the right of a person subject to an allegation of abuse to be informed at the earliest opportunity of the allegations, to receive copies of all documents relied on and to bring a support person with them when being interviewed.

**Example 3**

**Accused adult not told who had made the anonymous allegation**

Mr Smith (who worked with children) complained about the way the social work department had handled an anonymous allegation made against him. A person who said they wished to remain anonymous had made the allegation directly to Gardaí who had in turn notified Tusla. While Gardaí referred the details of the allegation to the social workers, details about the name and phone number of the alleged victim were not provided to Tusla at that time. This meant that social workers had no means of contacting the alleged victim to conduct a credibility assessment before meeting with Mr Smith.

Furthermore, within the allegation report even the most basic information was lacking. For instance, there was no information as to when or where the alleged incident occurred. The child who was allegedly present was not identified. It was alleged that Mr Smith had acted aggressively towards an adult in the presence of this unnamed child.

The allegation was subsequently withdrawn by the person who had reported it and ordinarily, in such instances, no further action would be taken. Notwithstanding this however, given the nature of Mr Smith’s professional involvement with children, the social workers decided to interview him, alert him to the anonymous allegation, and seek his response.

They wrote to Mr Smith inviting him to a meeting. This letter was sent to him six months after the social workers had received notice of the original anonymous allegation via the Gardaí. The letter simply stated that they wished to meet him in relation to an incident that allegedly involved himself and another person. The caption in the letter referred to a notification to the Gardaí about an incident. This letter caused Mr Smith considerable distress. It did not outline the nature of the allegation nor did it mention that he could bring a support person with him to the interview. It took a phone call from Mr Smith to the social worker to establish more fully the nature of the complaint against him before the meeting took place. This prompted Tusla to write to him again in advance of the meeting to outline the available details of the allegation.

Following the meeting the social workers asked the Gardaí for the name and contact details of the person who made the allegation. Two months later the Gardaí provided a mobile telephone number to Tusla but no name was provided at that time. The social worker felt it was inappropriate to ring the number without knowing the person’s name.
Three months after the social workers met Mr Smith, he was told that the allegation was deemed “unfounded”. The Gardaí were also notified of the outcome. At that stage, in response to the case closure notification from the social worker, the Gardaí decided to provide the social worker with the name of the person who made the allegation. The social worker left a telephone message asking this person to make contact with her but the phone call was not returned.

The social workers explained to Mr Smith that the assessment had taken longer than expected, as the alleged victim did not make contact with them. Mr Smith was understandably highly concerned about his Garda vetting status, as this could have a major impact on his employment. When he enquired as to whether the allegation would affect his Garda vetting, the social worker advised him that there was no such thing as a 100% clearance in the Garda Vetting Unit. Mr Smith’s life and livelihood was put on hold during this period of time due to the uncertainty about his Garda vetting.

Tusla told us that Garda vetting does not fall within its remit. However, instead of referring him directly to the Garda Vetting Bureau, the social worker gave information which was misleading. Mr Smith said that this information caused him uncertainty and added to his upset. After a further two months and following further correspondence with the social worker, Mr Smith was ultimately advised that his Garda vetting would not, in fact, be affected since the allegation had been deemed “unfounded”. Mr Smith still does not know who made the allegation against him. Tusla issued a written apology to Mr Smith for the way the anonymous allegation against him was handled.

### Example 4

**Written details of allegations not provided before interview and no credibility or risk assessments completed**

In another case, four months after allegations of physical and sexual abuse were made against Mr Lynch, both Mr & Mrs Lynch were invited to a meeting with an allocated social worker. The allegations had been made by Mr Lynch’s daughter who was no longer resident in the family home. Mr Lynch initially only received verbal notification of the allegations prior to the meeting but was provided with a written version at the meeting.

Mr Lynch’s denial of the allegations was documented in the social work notes. After the meeting, the social worker made no further enquiries in relation to the allegations and the couple’s teenage children who resided in the family home were not risk assessed. The couple said they lived in constant fear that their teenage children would be removed from their care because of these allegations. Had a timely credibility assessment of the allegations been undertaken and a risk assessment of their children been conducted, this would have alleviated the couples anxiety. No such assessments were ever conducted.
Example 5

Insufficient details provided before and during interview

Mr Brady’s complaint centred on the way a social worker interviewed him about retrospective allegations, which had been made against him. He complained that:

- he had not received a written account of the allegations before the meeting;
- that the allegations were not disclosed in their entirety during the meeting;
- that the social worker failed to notify the Gardaí about them (had this happened, he would, at least, have been made aware of the full extent of the allegations and been able to respond to them all);
- that the social worker did not take any notes of his responses to the allegations;
- that the social worker informed him that the case was closed even though he discovered she had yet to interview a third party.

Tusla explained that the allegations were considered credible in nature. However, as there was no other specific information from any other source on record (such as the Gardaí or any other third party) the allegations were placed on the social work waiting list for allocation.

Following her interview with Mr Brady, the social worker formed the view that there might be a potential risk to children based on the information provided during the meeting. The Ombudsman’s examination of the social work records showed, however, that the social worker did not seek to interview other relevant persons named by Mr Brady who may have been of assistance in determining the credibility of the allegations. This was not in accordance with the guidelines provided under the Barr judgment.

The social worker proposed that she would make contact with the parents of the children concerned to advise them about the unproven allegations so that they could consider whatever proactive measures they wished to take to reduce any potential risk to their children. Tusla explained that these allegations were assessed prior to the introduction of Tusla’s Policy and Procedures for Responding to Allegations of Child Abuse and Neglect (September 2014). Therefore, no appeals mechanism was in place to consider Mr Brady’s objections to the parents being notified of the allegations. In the event, the parents decided not to allow the children to visit Mr Brady’s home.

In relation to its failure to notify the Gardaí of the allegations, Tusla said that “Children First: National Guidance for the Protection and Welfare of Children” 2011 did not place a statutory obligation on social workers to notify the Gardaí of suspected cases of child abuse. Tusla did acknowledge, however, that Mr Brady should have been notified in writing of the allegations made against him and that the guidelines issued as part of the Barr judgment had not been followed. It apologised that fair procedures were not followed in this regard.
Example 6

No appeals process for respite foster carer

Mrs Reilly underwent an assessment process as part of her application to become a foster carer. The assessing social worker made a recommendation to the Foster Care Committee (FCC) that she should be approved as a respite/short term foster carer for one or two children in the age range of 6-11 years. The FCC approved Mrs Reilly for respite foster care only and took the decision not to approve her for short-term foster care. As Mrs Reilly was unhappy with the decision, she complained to Tusla.

The Complaints Officer responded that as Mrs Reilly had been approved as a foster carer, (albeit in a more restricted capacity than had been recommended by the social worker), there was no route of appeal.

Tusla accepted the Ombudsman’s view that it was not appropriate to refuse the opportunity of an appeal in such circumstances and the complainant was granted an appeal.

Findings

Tusla’s policies and procedures were not followed by social work staff which meant that:

- in some instances, the subject of an allegation of abuse was not provided with details of the allegations made against them in writing;
- in some instances, the subject of an allegation of abuse was not advised of their right to bring a support person to interview;
- adequate notes were not taken during the interview process;
- notes taken were not shared with the person subject to an allegation of abuse for verification purposes;
- the name of the person who made anonymous allegations was withheld from the person subject to an allegation of abuse which was not in keeping with Tusla’s September 2014 Policy;
- the subject of an allegation of abuse was not given a copy of Tusla’s September 2014 Policy so that they could understand the process which lay ahead.

Recommendations

- finalise and publish the policy for dealing with allegations by October 2017;
- provide training to all social work staff on the policy;
- regularly audit a sample of case files to ensure that the policy is being complied with.
Chapter 3

Notetaking and Record Keeping
Notetaking and Record Keeping

Public bodies should strive for the highest standards of administration in their dealings with people. This involves taking accurate notes of interviews or meetings and maintaining proper records. Proper note taking and record keeping is a fundamental component of good administration. The consequences of poor or inadequate record keeping can have profound consequences for all involved, including social workers. Accurate notes and records can greatly assist in any subsequent appeals, reviews or court actions.

Both the HSE and Tusla have developed policy documents, which provide direction in relation to note taking, case recording and the management of records. In addition, social workers are expected to comply with the Code of Professional Conduct and Ethics devised by the Social Workers Registration Board at CORU, which is the regulatory body for social workers. This Code specifies the standards of ethics, conduct and performance expected of registered social workers, which includes accurate record keeping.

HSE - Children and Families 2012 - Records Management Policy

This policy outlines what is considered good case recording and effective records management. It sets out what good case recording entails which includes the provision of accurate and timely records of involvement with individual service users, families and carers. The policy states that there should be clear records of how cases have been assessed and the information analysed to come to a planning stage.

The following provisions of this policy are of particular relevance to the complaints under discussion in this Chapter:

- for child protection cases, the worker should clearly outline the substance of the allegations and concerns being discussed with the service user and should record the views, opinions and responses of the service user;
- all records must be completed contemporaneously and placed on file within seven working days of a contact, communication or event;
- the worker should record who is present when information is being shared;
- the worker should ensure that opinions are unbiased, informed and evidence bases and conclusions are informed by available facts and evidence;
- assessment should contain analysis of information gathered;
- judgements made and actions or decisions taken should be recorded carefully, demonstrating fairness in these processes, underpinned by clear evidence.
- case recording should give reasons for actions and contain service user’s views and agreements.
Tusla’s policy (Policy & Procedures for Responding to Allegations of Child Abuse & Neglect – September 2014)

This policy document provides guidance on how allegations made about an adult should be handled. For example, it states that:

- once the interview with the person subject to an allegation of abuse is finished, he/she should be told that they will be provided with a copy of the typed notes of the interview and any other relevant information (some of which may have been given already);
- the social worker should retain all handwritten notes on file and the person subject to an allegation of abuse should be given the opportunity to notify any clarifications or inaccuracies within 10 days of the notes being sent to them;
- after the interview, the notes of the interview should be prepared and sent to the person subject to an allegation of abuse.

Accurate and comprehensive notes and minutes are essential if misunderstandings and subsequent disputes with regard to matters of fact are to be avoided. File notes and minutes should be compiled as soon as possible after the event as the level of recollection and accuracy is better. The date of the note and the date of the events should be clear and all written records should be fully signed. If electronic notes have been transcribed from handwritten notes by another party then this should be made clear in the electronic note. Notes of meetings should list the date, venue, purpose, time and length of the meeting along with a full list of those in attendance. If a direct quote is being cited in the minutes then it should appear in quotation marks.

In one complaint to the Ombudsman outlined below, allegations of abuse were misfiled and, as a consequence, were not followed up expeditiously. This could have affected the safety and protection of a child or children. If any record includes a judgemental statement, e.g. “Mr Brady was very aggressive” then any relevant evidence in support of such judgements should be cited in the records.

In addition, during the review of Tusla internal case files, two complaints related to information contained in documents or reports prepared for a court. It was claimed that this information was either inaccurate or incorrect. The general rule that applies in these cases is that the complaints procedure cannot deal with a matter that has been dealt with by a court. If a service user has an issue with a report before the court, the place to challenge it is in court.

Four Ombudsman Case Studies

1. Notes shredded

In one case, two social workers interviewed Mr Smith. One social worker took notes and subsequently typed up a minute of the interview and signed it. The original notes were shredded. Some weeks later, when Mr Smith obtained a copy of the minutes under Freedom of Information he disputed the contents. At his request, the social workers amended the report in relation to one factual inaccuracy. However, they declined to make any further amendments to the minutes. Mr Smith said that the minutes should have clearly documented the questions he was asked and the responses which he gave in chronological order rather than an overview of what was discussed. The original notes were not available to assist my staff in resolving this dispute. In discussion with the local Area Manager, my Office was informed that it was the general practice within that social work region to shred the handwritten notes once the typed (but not agreed) minutes were available.
2. Allegations misfiled

In a second case, Ms Flynn complained that when she made retrospective allegations in writing that a relative had abused her, they were misfiled. The allegations were discussed at a Tusla Child Protection Meeting and were thought to have been forwarded to a named social worker to assess their credibility. Having heard nothing for four months, she made a number of phone calls, which were not returned. She again wrote to TUSLA and subsequent appointments to meet her were cancelled three times at short notice. When the meeting eventually took place, she was told that the original statement had been misfiled. Ms Flynn provided another copy of her original disclosure letter.

3. Failure to record notes of meeting

In a third case, Mr Brady complained about the way the social worker interviewed him about retrospective allegations. Part of his complaint was that, at the meeting, the social worker did not take any notes of his responses to the allegations. When the Ombudsman reviewed the social work notes, it was clear that the detail in the notes fell well below the expected standard. This was accepted by Tusla who advised that training was taking place within the social work department in relation to note taking and record keeping.

4. Written consent not given for voluntary foster care

In another case, Mrs Kennedy whose son had been admitted into voluntary foster care complained that her signature was forged on the application form. She disputed that she had provided consent for her son to be admitted into voluntary foster care. She also said that her address was incorrectly given as that of her son’s address on the Standard Form for Reporting Child Protection and Welfare Concerns. This, she said, was not her correct address.

In responding to the complaint, Tusla denied that her signature had been forged. My staff noted that Mrs Kennedy’s signature did not appear at all on the “Application to Voluntary Care” form and had not, therefore, been forged. Tusla explained that her husband had signed the form and that the social worker had written on the form that Mrs Kennedy was too emotionally upset to sign it but had given her verbal consent over the telephone. However, there was no written record of this telephone conversation and Mrs Kennedy denied that any telephone conversation with regard to her consent had taken place. Tusla accepted that this, together with the use of her incorrect address, were administrative weaknesses and apologised to the complainant. It acknowledged that when verbal consent is being provided, best practice would be to subsequently seek written consent at the earliest possible opportunity. On foot of this case, Tusla issued guidance nationally which highlighted best practice in obtaining parental consent for voluntary foster care.

Tusla will need to satisfy itself that this policy is being properly implemented.
Findings

- notes taken during interviews were shredded before their contents were verified with the person subject to an allegation of abuse;
- inadequate or inaccurate notes were taken during the interview process;
- Tusla’s September 2014 Policy was not followed which sets out how social work notes should be recorded and maintained.

Recommendations

- reinforce the requirements of good note keeping as part of the training package;
- where issues relate to individual practice, training and other learning and development responses such as mentoring, coaching and performance management should be considered;
- consider the introduction of audio recording to avoid disputes about the content of interviews;
- interview notes to be retained at least until the typed note of the interview is agreed by the person subject to an allegation of abuse. There are situations where the notes may never be agreed by attendees, in which circumstances, a record of the meeting with a note of the points of dispute should be retained.
Chapter 4

Communication
Communication

Poor communication is a feature of almost every complaint received by the Ombudsman. Sometimes the way information is given is overly technical or distorts its true meaning. Sometimes the message is hurried and basic information is omitted or unclear. Cultural diversity and language differences can also cause difficulties between service users and service providers. Every effort must be made to ensure that information is communicated to people in a clear, respectful manner and in a way which they can understand. Good communication involves thinking about who needs to know, what they need to know and how that information should be conveyed.

Code of Professional Conduct and Ethics

For social work staff whose work brings them into daily contact with vulnerable children and adults, the ability to communicate effectively is essential. This is reflected in the regulatory body’s Code of Professional Conduct and Ethics for social workers which says that:

- social workers must make sure that they communicate properly and effectively with service users, their carers and their family.

Tusla’s Policy and Procedures for Responding to Allegations of Child Abuse and Neglect – September 2014

Tusla’s policy for handling allegations against adults centres on the need for sensitive communication between all of the parties including the referrer, the person subject to an allegation of abuse, the Gardai and the social workers. The language used in that policy document sets out how social workers should approach the task of dealing with such allegations. They must explain the process to the referrer and to the person subject to an allegation of abuse and inform them of the various stages of assessment.

Guidance is also provided about the need to confirm the details of the allegations in writing to the person subject to an allegation of abuse. In addition, it is the role of the social worker to interview children who may present themselves without the knowledge or presence of their parents. Again, the need for clear and sensitive communication is essential in these situations.

Case Studies

The case studies, which are included in this chapter, show how poor communication can lead to misunderstanding, conflict and complaints. In some instances, we see a lack of time given to discussion with the people involved or that the approach taken is perceived as being biased or lacking in empathy.
Example 7

**Sensitive correspondence sent twice to the wrong address**

In this case, Ms Flynn made retrospective allegations, which had been misfiled by the social work department. She met with a senior social worker to provide a second copy of her original statement. The senior social worker assured her that a report of their meeting would be written up and posted to her. While the senior social worker did write to Ms Flynn after this meeting, the letter was not received as it was sent to the wrong address.

Due to the apparent lack of contact from the social work department, Ms Flynn telephoned Tusla Head Office and a support person was appointed to assist her. She was advised that all her concerns were in hand and that the support person would find out what was happening in the case. Correspondence from the support person to Ms Flynn was not, in fact, received either as it was also sent in error to an incorrect address. In addition, when Ms Flynn complained about this second postal error, the support person told her that she was being overly sensitive and blowing matters out of proportion.

Example 8

**Interaction with foster parents after short-term placement**

Mr & Mrs Jones had fostered a new baby for seven weeks as part of a short-term placement. Mrs Jones had found it difficult to hand the baby back when the time came for the baby to be moved to a long-term placement. Although the placement itself had gone very well, Mrs Jones said that their link social worker had criticised her for becoming too attached to the infant during the placement. Mrs Jones acknowledged that she had bonded very well with the baby and had cried when a long-term placement was found. However, in responding to my Office, Tusla accepted that the social worker’s approach could have been more reassuring during the post placement review and that her manner lacked compassion and empathy.

In addition, the social worker had been critical of Mrs Jones for not providing sufficient clothing, nappies and bottles for the baby when the infant was moving to the long-term placement. This caused Mrs Jones much upset given her attachment to the infant. She believed that she had provided all that the social worker had requested of her. In this instance, she suggested that social workers should provide a written checklist to foster parents in order to avoid any misunderstanding as to what is required of them.
Example 9

**Level of communication with foster mother**

Ms Stone, who was a foster carer, complained about the level of communication with the foster child’s social worker whom she felt was not available when she needed support. The foster placement had broken down and the child had made a complaint about Ms Stone’s care. A Foster Care Review (FCR) was subsequently undertaken by the Foster Care Committee (FCC).

The National Standards for Foster Care state that regular reviews of placements should take place. These reviews are to examine the continuing capacity of the foster carer to provide high quality care. Additional reviews take place if concerns arise or if a complaint has been made, as had happened in this case. Social workers prepare reports which are submitted to the FCC.

Ms Stone complained that the content of the social worker’s report had not been communicated to her and that she had not been given access to all material prepared for the FCC. She also felt that she was denied the opportunity to respond to the social worker’s oral contribution to the FCC. The review had resulted in a decision to change Ms Stone’s approval status. Although she was not removed from the panel, limitations were placed on the children she could foster. She wished to appeal this decision but she was denied the right to do so.

In responding to my Office, Tusla acknowledged that there had been some communication difficulties between Ms Stone and the child’s social worker. It also agreed that in line with fair procedure, Ms Stone should have had the right to view and respond to all reports about her which had been submitted for consideration by the FCC. She should also have had the right to appeal the decision on her revised foster carer approval status.

Example 10

**Breakdown in communication during and after foster placement ended**

A foster mother of two children, Mrs Moore, complained about her interactions with the social workers responsible for her foster placements. The placement with one child had broken down and she felt that she had not received appropriate support from the fostering services at the time. Communication with her after the placement ended was poor and she received no information as to how the child was doing.

“I asked the social worker how Mark was doing and her response was “ok”. It was a very poor answer given to somebody who knew Mark as we did. She neglected to tell us that he wasn’t making his Holy Communion and I heard it a few days later at the school gate. It seemed everyone else was able to tell me what was happening with him yet the people who should have told me didn’t”.

Mrs Moore said she felt that the social worker’s manner towards her was disrespectful and abrupt. After the placement had ended, Mrs Moore had requested a receipt for the child’s savings and other items, which she had passed to the social worker, but this was not provided.
Difficulties had also arisen in their communications during the placement about a passport application, which necessitated Mrs Moore having to seek an emergency passport for one of the children the day before the family holiday.

The Ombudsman’s Office discussed the complaint with Tusla and arrangements were made for a senior person to meet with Mrs Moore. The senior person apologised to her for the tone of the Complaint Officer’s report and the approach adopted in it. She also apologised for the poor support available to her and undertook to address the practice issues identified by Mrs Moore with the social work staff concerned.

According to the National Standards for Foster Care, Link Workers should ensure that counselling is available to foster carers and their children where a placement breakdown has occurred, or after other critical events. Indeed, Tusla’s National Policy and Procedure on the Role of the Fostering Link Worker, states that fostering link workers are expected to provide support and to facilitate carers when placements end in an unplanned way through counselling and the holding of disruption meetings. In this regard, the Irish Foster Care Association has previously recommended that Tusla develop:-

- better lines of communication between carers and social workers regarding the process of seeking support for children in care – with more involvement of carers in key decision-making processes;
- better defined policies in place by Tusla to provide guidance and structure to those seeking support;
- the formulation of a statement of process by Tusla concerning the procedures by which a carer may seek support for children in care, or the carers and their families; and
- the formulation of a defined quality process to address complaints or concerns when carers feel they have been treated unfairly as a consequence of seeking support.

In responding to a draft of this Report, Tusla said that in January 2016, it had initiated a process of consultation with the Irish Foster Care Association to pro-actively identify service gaps from a national perspective. This process brought together over 300 foster carers and social workers to discuss solutions to the challenges they faced in providing foster care services. The findings are reported under key headings such as culture, policy, systems, capacity and technology. A briefing paper to reflect the findings of the consultation will be published in the coming weeks.
Findings:

- social workers in some cases did not demonstrate good communication techniques and appeared to lack empathy;
- counselling services and support (as per National Standards) should have been offered when the fostering placement ended in an unplanned way
- confidential communications issued to an incorrect address on two occasions.

Recommendations:

- each social worker should be requested to ensure that they have up to date contact details for each open case and that these details are validated through supervision;
- the medium of communication should be agreed with the individual in advance (e.g. email only) and ensure that personal and sensitive information is protected;
- training to be provided to social workers where there is evidence through complaints or otherwise that communications have not reached the expected standard or when the National Standards for Foster Care have been breached.
Chapter 5
Support and training for staff
Support and training for staff

All practising social workers in Ireland must be registered with CORU. CORU regulates a range of health and care sector professions including social workers. There is an onus on social workers employed by Tusla to continuously strive to maintain and update their knowledge, skills and performance. There is an onus on Tusla, as an employer, to take active measures to support and train their social work staff. This is in the interest of their professional development but, more importantly, it is in the interest of the members of the public whom Tusla is statutorily obliged to protect and serve.

Below is an extract from Section 23 of CORU’s Code of Professional Conduct and Ethics for Social Workers:

*Keeping your professional knowledge and skills up to date*

a) You must make sure that your knowledge, skills and performance are of a high quality, are up to date and are relevant to your practice.

b) you must:

- maintain and develop your professional competence by undertaking relevant education and training to improve your knowledge and skills;
- keep up to date with relevant knowledge, research methods and techniques so that your service, research activities and conclusions will help and not harm others. You can do this, for example, by reading relevant literature, consulting with peers and taking part in continuing education activities;
- take part in continuing professional development (CPD);
- Keep clear and accurate records of CPD.

Tusla has in place a Staff Supervision Policy (2013) (Standard Operating Procedures). (This is currently being redeveloped and a new framework is being developed on a phased basis entitled “Signs of Safety” which is designed to enhance current practices for staff. The cultural change potential of “Signs of Safety” practice emphasises working with families and helping them to find their own solutions rather than being told what to do. This represents a fundamental cultural shift in child protection work, both in the practice and the organisation.)

The current staff supervision policy places an obligation on all staff to work strictly in compliance with the relevant policies, procedures and regulatory obligations and places an obligation on supervisors to ensure that staff do so. However, it is important that at Agency level, senior management is in a position to quality audit and benchmark the standard of service at the point of delivery. Any evidence
of service failures will need to be analysed and followed up through additional training and support for staff. Comprehensive reporting and analysis of local complaints can be highly informative in identifying local issues at Agency level, thus enabling the Agency to provide the proper response.

A service provider that actively manages and supports staff will not only improve the quality of service but will increase staff morale and increase public confidence in the provider.

Working as a social worker is complex, demanding, and often very stressful. Social workers have to manage competing demands, work alone or within teams and with other regulatory agencies and public bodies. A social worker must comply with and fully understand a wide range of protocols, procedures and statutory obligations. Tusla’s website has a Catalogue Index listing its Policy, Procedures and Guidance Documents. This lists approximately forty separate documents, many of which relate to the day-to-day work of social workers. Against this backdrop, comprehensive training and support for social workers and other staff is essential. Communication with all staff is a critical part of any policy implementation strategy. Through ongoing training and learning from their more experienced colleagues, newly qualified or recently appointed social workers will also quickly learn how to apply a particular policy to their practice. This is preferable to placing a policy document on an internal website without any training and asking them to apply it.

**Ombudsman’s Workshop**

As part of the investigation process, the Ombudsman hosted a Workshop (see Appendix 4) which was attended by 30 mainly social work staff, most of whom had responsibility for complaint handling as part of their duties. The attendees completed an anonymised survey at the Workshop which provided an insight into their experiences of complaint handling. One of the topics covered was training and development for Tusla staff.

In their responses 95% said that no training was provided on complaint handling but that this was due to take place in 2017. One person commented that they had not received any training until attending the Ombudsman’s Workshop. Another said that the video played as part of the Workshop was a real “eye-opener” on the importance of dealing fairly with complaints and that awareness of this should be made to all staff through training and at departmental meetings.

The video had been made by the Office of the Ombudsman as part of the systemic investigation into complaint handling in the acute hospital sector (Learning to Get Better). It featured complainants who outlined their experiences in making complaints about hospitals to the HSE.

99% of those surveyed said that no training or guidance is provided when new policies are introduced. One commented that it is up to the local area to provide training for staff. Another said that the implementation of policies is different in all areas across the services because of inadequate training.

The Tusla complaints policy “Tell Us” includes a commitment by the Agency to provide on-going comprehensive training for complaint officers and review officers so it is important that it fully meets that commitment.

Tusla is a very large organisation with staff deployed and managed throughout the country in local and regional areas. In light of this and reflecting back on the Workshop feedback, best practice would suggest there is a need to ensure that when a new policy, procedure or legislation is being implemented that there is a thorough and consistent approach taken to the delivery of training and information to all staff. Clearly senior management have an important role to play in ensuring that this happens.
Without training, mentoring and auditing, it is inevitable that policies, procedures and legislation will not be interpreted or implemented in the same manner throughout the country. Over the years, the Office of the Ombudsman has frequently seen large service providers, which operate in different areas of the country (e.g. local government and the HSE) taking contradictory or incorrect positions in implementing centrally driven schemes, policies and procedures.

In responding to a draft of this report, Tusla said that it was incorrect to state that training in complaint handling was not provided to complaints officers. It said that while training on “Tell Us” has not as yet been rolled out in full, many Tusla staff have received training in complaint handling under the previous complaints policy “Your Service, Your Say”. It also disputed the view that Tusla has no mechanism to share learning from complaints. In this regard, Tusla said it issued a Service Experience Report in Q1 and Q2 (2016) to Area Managers outlining trends in complaints being received by the Agency. It added that email and phone support is now regularly provided by members of the Service Experience Team to staff members dealing with complaints. Since the Ombudsman’s Workshop, Tusla has also commenced briefing staff and managers on their roles and responsibilities in handling complaints.

However, there is a contrast between Tusla’s view on training and shared learning and that of the staff who were surveyed, and it is evident that the work on managing complaints needs to be continually assessed and improved.

Findings

- Tusla’s Staff Supervision Policy was not properly implemented in light of the failure by staff in the case studies to follow Tusla’s Policy and Procedures for Responding to Allegations of Child Abuse and Neglect;
- there is a delay in the provision of training for staff when new policies are introduced;
- there is no evidence to suggest that auditing is taking place with regard to the implementation of all Tusla policies.

Recommendations

- require Area Managers to document the action taken when failures are identified and to record the outcome of such action;
- the annual training plan to include training for all staff on new policies which have been introduced;
- comprehensive case audits to take place to ensure that all policies are being followed and that the desired outcomes are being achieved. Any shortcomings identified to be fed into reviews of policies and procedures, support for individual staff members and training programmes.
TAKING STOCK
An investigation by the Ombudsman into complaint handling and issues identified in complaints made about the Child and Family Agency (Tusla)
Chapter 6

Management and recording of complaints and complaint handling
Management and recording of complaints and complaint handling

In developing this Chapter, we have taken examples from the Ombudsman’s nine case files, from the 30 complaint files provided by Tusla and from the Questionnaire completed by complaints officers who attended the Ombudsman’s Workshop.

Management and recording of complaints

Tusla Quality Improvement Framework

In October 2016, Tusla’s Quality Assurance Directorate finalised a Quality Improvement Framework aimed at mapping out the agency’s approach to improving the quality and safety of services at all levels. The document acknowledges that the full implementation of the framework would take a number of years. The document indicates that the framework is due for revision in October 2018.

The document explores a number of high-end goals and points the way towards how they should be realised. The key overall components are Defining Quality, Assessing Quality and Improving Quality.

It is commendable that the agency has sought to highlight the need to deliver a high quality service and that there was engagement with staff at all levels in the development of the framework. This included eight workshops with staff and consultation with all staff via an on-line survey.

The document stresses the need to collate, analyse and integrate data and information from a variety of sources, including service users, as a management tool to drive performance and to improve the quality of service.

In terms of explicit reference to complaint handling, the document refers to the need to ensure that complaints and feedback are managed.

Tusla is a large and complex organisation. Quality improvement at individual and organisational level can be approached internally in a variety of ways. This includes training, mentoring and development, proper guidelines, policies and procedures, robust case management and line management and continuous feedback and process improvement.

Inevitably, however, systemic or individual errors occur leading to adverse effect on service users or persons under investigation. This is why information on complaints, if properly recorded, managed and analysed is key to quality improvement. This information can provide an early warning system. It makes management aware that something went wrong and why it went wrong. Remedial action can be taken in the individual case, if necessary, systems can be revised, other similar cases may need to be reviewed and organisational learning should follow.
The revision of the Quality Improvement Framework should be seen as a good opportunity by Tusla to put in place a strategy for proper complaint information management and analysis as well as devising procedures for proper follow up on adverse complaint outcomes and negative trends. Such a strategy needs to be supported by IT systems, which are capable of providing comprehensive management information on complaint levels and trends. While some work has been done in this area, there is clearly scope for improvement as explained below.

National Database for managing complaints

In January 2016, Tusla began to use the National Incident Management System (NIMS) in place of the local recording systems that had been used previously. Tusla is working with the State Claims Agency regarding the roll out of NIMS for both incidents and complaints. However, while some training has been provided for staff on the use of this new system, not all areas are actively using it. The implication of this is that the information available is not comprehensive and that the full benefits of gathering and coordinating useful complaint data to inform service improvement is not being fully realised. If the system is to produce useful data, it is important that complaints are logged, tracked and managed consistently across the services. It is also important that all relevant staff are trained in the use of the system and that regular audits of compliance take place. Otherwise, the system will not function effectively.

The NIMS system was not originally designed for handling complaints in a social care setting. This will need to be formally evaluated to ensure that it is fit for purpose.

Complaint Handling

Good complaint handling is an essential component of public administration. It is important that public service providers deal with people properly, fairly, openly and impartially. If a person feels that they have been treated unfairly, they will complain. Complaints provide useful information and feedback for the services concerned and they should be handled correctly and within a reasonable period. How service providers respond to complaints speaks volumes about their willingness to learn from them and to improve the way they deliver their services.

In September 2016, Tusla launched its own complaints policy and procedure, “Tell Us” which sets out the process for dealing with complaints and feedback. Prior to this, the Child and Family Agency used the HSE’s complaints process “Your service, your say” to facilitate a person who wished to make a complaint about a service provided. “Tell Us,” explains in a child friendly way how complaints or feedback can be provided with a focus on local and speedy resolution. Where informal local resolution is not possible, a Complaints Officer will be appointed to examine the matter. This process might take up to 30 days. If it takes longer, the process provides for regular updates every 20 days. If, after that, a person remains unhappy, they can either seek a review of their complaint by a Tusla Review Officer or contact the Ombudsman/Ombudsman for Children’s Office.

It is clear from the complaints which have come to the Ombudsman that, at present, there are insufficient review officers within Tusla to conduct reviews. This has meant that complaints are not progressing to review stage, which is a breach of the complaints policy. The only option for a complainant in this position is to come to the Ombudsman/Ombudsman for Children. The removal of the review stage is an option which should be considered but which would require a change in legislation. However, if the review stage is being retained it must be properly resourced.
Many of the complaints referred to in this Investigation Report reflected difficulties with regard to poor communication, such as the failure to acknowledge or return letters or phone calls or to provide updates as required by the policy. Other aspects of the service complained of related to behaviour or staff attitude or insensitivity during interactions with adults. In many instances, Tusla handled these complaints in a defensive way that left the complainants feeling unheard and unhappy. It is of course essential that, in appointing review officers, Tusla ensures that they are properly trained in complaint handling.

**Ombudsman complaint studies**

**Example 11**

**Complaints Officer’s recommendation ignored**

Mr & Mrs Lynch sent a written complaint to the HSE (subsequently Tusla) about the delay in granting them supervised home access to their grandchildren. The Complaints Officer recommended that a meeting take place within a specified timeframe between the social workers to agree a credibility assessment plan. For reasons that are unclear, the Complaints Officer’s recommendation was not implemented within the specified timeframe. While the meeting did eventually take place, this only happened following the Ombudsman’s involvement in the case.

**Example 12**

**Complaints Officer’s report factually inaccurate**

Mr & Mrs Jones said that their written complaint to the HSE (subsequently Tusla) had not been dealt with fairly or in a timely way. During the examination of their complaint, it became clear that no attempt had been made by the Complaints Officer to meet with the couple to discuss their concerns or to resolve them. In addition, some of the details in the Complaints Officer’s response were factually inaccurate and did not reflect what was contained in the social work records. During the Ombudsman’s examination of this complaint, it became clear that the Complaints Officer had relied on a report provided to her by the Social Work Team Leader and that she had not independently reviewed the social work records to verify the contents of the Team Leader’s report.

Had the Complaints Officer offered to meet with the couple to discuss the issues of concern to them in the first instance, this may have helped to resolve matters informally.

When the couple requested a review of their complaint, the same Complaints Officer reviewed it in her capacity as the newly appointed Area Manager. It represented a clear conflict of interest. This should not have happened. It was not an independent review of the complaint.

The way this complaint was handled heightened the couple’s upset and caused their relationship with the social work department to deteriorate to the point that they withdrew from fostering. While Tusla apologised to the couple for the way they had been treated as foster parents and for the way their complaint was handled, it had taken three years and the Ombudsman’s intervention to resolve matters.
Example 13

Tone of Complaints officer’s report was defensive

Mrs Moore’s complaint centred on a number of care issues, which had arisen during a foster placement. A meeting took place with the Complaints Officer in January 2016 to discuss the concerns but Mrs Moore heard nothing further until she received a report some four months later. Most of the concerns which she had raised had been deemed unfounded in the report which was defensive in nature.

The Ombudsman discussed the complaint with Tusla and arrangements were made for a more senior person to meet with Mrs Moore. The more senior person apologised to her for the tone of the Complaints Officer’s report and the approach adopted in it. She also apologised for the poor support available to her and undertook to address the practice issues identified by Mrs Moore with the social work staff concerned.

Issues arising from review of Tusla internal complaint files

The Ombudsman’s review of 30 internal complaint files showed some evidence of good complaint handling.

Cases that showed evidence of good complaint handling

- an apology was given for the failure to return the complainant’s phone calls and a meeting was held with the complainant before the Complaints Officer’s report issued;
- following a complaint about local arrangements for the payment of the Aftercare Fostering Allowance during summer months, a national policy was implemented which ensured that a more consistent approach was taken to payment of the allowance;
- an anonymous allegation about a foster parent was handled in a thorough, timely and fair way with the process being fully explained;
- a complaint from a woman whose children were in foster care was addressed promptly through regular meetings with her and her advocate;
- a woman complained about the lack of support from her assigned social worker. Meetings were arranged between the woman and the social worker during which they jointly resolved matters quickly to her satisfaction;
- another complaint about lack of contact from the allocated social worker in a relative foster care placement was particularly well handled. It involved the Complaints Officer acknowledging and apologising for the lack of support, reviewing the file notes, meeting with the complainants and the social work team and drawing up an action plan for the future.
Cases where there was room for improvement

- one complaint related to the making of twenty eight phone calls to the social work department four of which had been returned;
- in a case where the Complaints Officer had upheld several aspects of the complaint no apology was given for those shortcomings;
- insufficient information was provided to complainants about the complaints process. In a number of cases, complainants were not updated during the complaints process. In ten cases, no information was given about the right to seek an internal review of the complaint and complainants were not signposted to the Ombudsman.

What Tusla staff told us:

The answers given to the Ombudsman’s Questionnaire by attendees at the Ombudsman’s Workshop gave helpful insight into the difficulties facing Complaints officers. Only one person had a dedicated, full time role as a Complaints Officer. All others had additional roles and duties in an operational capacity, which affected their ability to handle complaints in a timely way. There was no forum for Complaints Officers to meet up and to share or learn from the complaints they had examined. Some did say that they felt supported by their line managers and by staff in Head Office.

95% of attendees said they would always seek the case records when examining a complaint and would not simply rely on the response provided by the team. One person said they would rely on the report provided by the Principal Social Worker who would have reviewed the records. Another said they wouldn’t always seek the case records due to time constraints while another would always ask the complainant for permission to access their records and would always review them.

In relation to awareness of the complaints process, 70% of attendees said that they were fully aware of what was expected under the policy. Others commented that these issues were discussed at team meetings and departmental meetings but that training was essential in relation to “Tell Us”.

With regard to complaint handling, 95% said that no training was provided on complaint handling but that this was due to take place in 2017. One person commented that they had not received any training until attending the Ombudsman’s Workshop. Another said that the video played as part of the Workshop was a real eye - opener on the importance of dealing with complaints and that awareness of this should be made to all staff through training and at departmental meetings.

The attendees made the following comments and suggestions as to how complaint handling could be improved:

- need for quicker response and processing times;
- use trained, dedicated Complaints Officers in each area;
- have independent, trained Review Officers as standard to undertake all formal reviews;
- complaints are not always prioritised amidst day to day work – need to provide training to emphasise the importance of learning from complaints;
- develop an app for young people who are technology focused to assist them in making complaints;
learning from complaints needs to be shared within the organisation;
complainants need advocates to frame their complaint and have people to assist them through the process;
professional defensiveness needs to be reduced and we need to see complaints as positive learning opportunities;
adequate training in process and implementation of new complaints policy is required with more time to deal with complaints. As a Manager, I do not believe that I should be a Complaints Officer as I may not be impartial;
need to keep the complainant informed during the process;
need to have a clear cut off point or closing down of a complaint;
need to provide staff with feedback when a complaint about the service has been made;
sometimes it seems that people pass complaints on and nobody addresses the complaint, forgetting that there is a real person at the end of the letter;
need to filter out vexatious complaints;
need to meet the complainant as soon as possible to avoid frustration and escalation of the complaint – should be standard requirement as part of the process.

Findings:

- complaints were not dealt with in a timely way and complainants were not updated in line with the relevant complaints policy;
- the tone of the response in some Complaints Officers’ reports was overly defensive;
- the use of independent advocacy was not considered to support complainants;
- mediation could have been used to resolve complaints in some instances to assist local/informal resolution;
- ongoing training in complaint handling was not provided to Complaints Officers;
- there was no mechanism for Complaints Officers to share the learning from complaints with each other;
- while staff were trained to use the NIMS system to record complaints, not all staff were actually using it;
- social work records were not reviewed as part of the examination of some complaints;
- there were lengthy delays in assigning review officers to conduct reviews.
Recommendations:

- all complaints to be properly recorded on the NIMS system;
- the use of the NIMS system to be evaluated to ensure that it is fit for purpose in respect of categorising complaints, managing complaints and identifying trends arising from complaints;
- dedicated and properly trained Complaints Officers to be appointed across the regions together with the development of a sharing and learning network to provide support and build expertise;
- quarterly casebooks to be prepared to share learning at local, regional and national level;
- managers at all levels and the Board to have clear visibility of complaint outcomes and to take responsibility for developing action plans and monitoring implementation and successful outcomes;
- consideration to be given to changing the complaints process to eliminate the review stage and encourage earlier access to the Ombudsman. This would require a statutory amendment. In the interim, the review stage should be properly resourced, and failures identified in complaint handling at this stage be used as a source of learning;
- advocacy services should be made available to assist complainants as required;
- consideration should be given to the use of mediation to help resolve complaints locally in the first instance;
- consideration should be given to the development of apps or other social media mechanisms to make it easy for individuals to complain.
Chapter 7

Signposting to the Ombudsman
Signposting to the Ombudsman

The Ombudsman (Amendment) Act 2012 states that if a decision penalises or otherwise adversely affects a person then the reviewable agency must:

(a) give reasonable assistance and guidance to that person in any dealings of the person with the agency in relation to the action taken by the agency, having particular regard to the needs of the person as a result of any disability,

b) ensure that the business of the person with the agency in relation to that action is dealt with properly, fairly, impartially and in a timely manner, and

c) provide information to the person on any rights of appeal or review in respect of that action and on the procedures for, and any time limits applying to, the exercise of those rights.

In light of the foregoing, it is therefore incumbent on service providers subject to the Ombudsman’s remit, including Tusla, to advise complainants about their rights to seek a review of their case and/or to complain to the Ombudsman. These rights should be included in all decision letters and on the appropriate area of each service provider’s website.

As part of this investigation, the Ombudsman’s Office reviewed 30 Tusla internal complaint files. Of these case files, 10 were found not to have provided any information about a right of review and/or entitlement to complain to the Ombudsman.

Findings

- information about the right to seek a review following the examination of a complaint was not provided in every case;
- a significant number of complainants were not advised of their right to make a complaint to the Ombudsman.

Recommendations

- all staff should be made aware of their obligation to comply with notification proceedings as set out in “Tell Us” and to provide reasonable assistance to individuals as provided for under Section 4A of the Ombudsman (Amendment) Act 2012;
- the text for such notifications should be agreed with the Ombudsman’s Office.
Appendices
Appendix 1

Notification of Investigation to Tusla

23 June 2016

Mr Fred McBride
Chief Executive
Child and Family Agency (TUSLA)
The Brunel Building,
Heuston South Quarter,
Saint John’s Road West,
Dublin 8.
D08 X01F

Dear Mr McBride

Notification of Investigation into Complaint Handling in the Child and Family Agency (TUSLA) – (cc Liaison Officer)

I wish to notify you of my intention to initiate an investigation under Section 4 of the Ombudsman Act 1980, as amended, into the way complaints are dealt with by the Child and Family Agency. This follows on from the examination of a range of complaints by my Office about the interactions of social workers with complainants over the past two years.

The investigation will seek to determine if there is scope for improvement in TUSLA’s administration of social work cases in areas such the application of the Children First Guidelines, the implementation and application of TUSLA’s own policies and procedures, the obligation to follow fair procedures and natural justice, and the proper handling of complaints. Some of the complaints previously examined and which may be included in the investigation are as follows:

“Names redacted”

Having conducted a preliminary examination of the complaints, I am of the view that actions may have been taken by TUSLA which adversely impacted on the complainants, on the basis of one or more of the grounds set out in Section 4(2)(b) of the Ombudsman Act 1980, as amended-

(i) taken without proper authority,

(ii) taken on irrelevant grounds,

(iii) the result of negligence or carelessness,

(iv) based on erroneous or incomplete information,

(v) improperly discriminatory,

(vi) based on an undesirable administrative practice, or

(vii) otherwise contrary to fair or sound administration.
This will be a wide-ranging investigation which will involve a look back at the social work related complaints which my Office has examined and concluded since the establishment of TUSLA. It may also reference cases which I am currently examining and a review of complaints which TUSLA received but did not reach my Office. All cases included in this investigation report will be anonymised to protect the identity of the complainants and their families. Furthermore, TUSLA staff involved in any of the individual cases examined during the investigation or their geographical areas will not be identified in the investigation report as the investigation will be generic in nature. As a consequence, the question of redress or further redress being recommended in any individual case examined during the investigation will not arise.

I expect that this investigation will culminate in a report towards the end of 2016 or early 2017.

Investigation Process

I have previously outlined my plan to undertake this investigation when I met with the Director of Quality Assurance and the Liaison Officer last April and I warmly welcome the assistance of the Child and Family Agency. In order to gain a better understanding as to how complaints which did not reach my Office were handled, my staff will require access to complaint files held by TUSLA. It may also be necessary to hold formal interviews with complaints officers or senior staff within TUSLA. In the event that the investigation results in adverse findings or criticism of TUSLA, I will, as required by section 6(6) of the Ombudsman Act 1980, as amended, provide an opportunity to TUSLA to consider the finding or criticism and to express its views for my consideration before the final findings and recommendations are published.

In order to ensure that the investigation proceeds as efficiently as possible, I would be grateful if you would nominate a senior person within the Agency to liaise with my Office. The person nominated should be familiar with the issues and should have the authority to speak on behalf of the Agency, or, in the alternative, to ensure that the position of the Agency be ascertained speedily and authoritatively. Other than the nomination of that person, I am not at this stage seeking any specific response from the Agency. However, if the Agency so chooses, it is welcome to make any written submission it wishes and/or to provide any documentation it believes relevant to the investigation.

Ms Patsy Fitzsimons, Investigator, (patsy.fitzsimons@ombudsman.ie) will manage the investigation. I would be grateful if the Agency’s nominated person would make direct contact with Ms Fitzsimons to deal with any queries which might arise and to agree working arrangements for the conduct of the investigation.

Your cooperation in this matter is greatly appreciated.

Yours sincerely

Peter Tyndall
Ombudsman
Appendix 2

Methodology

The primary impetus for this systemic investigation into the way complaints are handled within the Child and Family Agency (Tusla) was the number of complex complaints received in recent years by the Ombudsman that were not handled in accordance with the complaints policy or good administrative practices.

The three main strands of the investigation involved:

a. a review of a number of complaints made to the Ombudsman;

b. a review of a number of complaints handled locally by TUSLA which had not come to the Ombudsman, and

c. a half-day workshop hosted by the office of the Ombudsman for Tusla complaints officers.

The investigation was generic in nature and reference to the cases in the investigation report were anonymised with the focus being on systemic learning and improvement. The procedures were looked at in the context of the regulatory framework under which Tusla operates (Appendix 3).

Review of Ombudsman Cases

The investigation involved a review and analysis of nine challenging complaints from adults, which were examined by the Ombudsman over the period 2012 - 2016. The vast majority of the cases had been completed with outcomes agreed with Tusla prior to the start of the investigation. Of the nine cases, reviewed five relate to foster care complaints and four relate to interactions with social workers, mainly in the investigation of retrospective allegations of abuse against adult complainants. In some of the cases the early events took place while the HSE had responsibility for social work complaints but by the time the examinations had been completed Tusla had responsibility for them.

The case reviews focused on a number of key themes, which included:

- undue delay in dealing with allegations of abuse
- right to fair procedures and due process
- note taking and record keeping
- communications - responding to complainants
- support and training for staff
- management and Recording of Complaints and Complaint Handling
- signposting to the Ombudsman
Review of Tusla Files

With the cooperation of Tusla, the lead investigator visited its Head Office to inspect a random sample of thirty Tusla complaint files nationally in an effort to assess the adequacy of local complaint handling in cases, which had not come to the Ombudsman. It had been agreed with Tusla’s Ombudsman Liaison Officer that the complaint files he would make available would be a mix of files randomly selected from across the four regional areas (Dublin North East, Dublin Mid-Leinster, South and West). The files would be taken from a range of Tusla national services (adoption, residential, domestic violence, education and welfare and child protection). It should be noted that the inspection was confined to Tusla’s complaint handling files and did not extend to the inspection of the social work records relating to the cases. The purpose of the file inspection was not to look at the substance of the complaints or to seek to have them revisited but rather to consider the complaint handling processes. This included such issues such as:

- were fair procedures and the principles of natural justice adhered to;
- was record keeping of a proper standard;
- were complaints dealt with speedily and thoroughly, and
- were outcomes supported by the evidence.

Ombudsman’s Workshop

The Office of the Ombudsman hosted a half-day workshop for TUSLA complaint handlers from around the country on 6 December 2016. Approximately 30 people attended. At the Workshop, presentations were made on the role of the Ombudsman and the purpose of the investigation. Feedback was also received from attendees on their day- to- day work and an anonymous survey questionnaire was completed by the attendees. The Questionnaire itself and the results are set out in Appendix 5.
Appendix 3

An Overview of Tusla – the Child and Family Agency

The Child and Family Agency was established on the 1 January 2014 under the Child and Family Agency Act 2013. The Child and Family Agency became an independent legal entity, comprising of HSE Children & Family Services, the Family Support Agency and the National Educational Welfare Board, as well as incorporating some psychological services and a range of services responding to domestic, sexual and gender based violence. The Child and Family Agency is now the dedicated statutory agency responsible for supporting and promoting the development, welfare and protection of children and supporting and encouraging the effective functioning of families.

History

The programme for Government 2011-2016 committed to a reform in child protection services. It stated “We will fundamentally reform the delivery of child protection services by removing child welfare and protection from the HSE and creating a dedicated Child Welfare and Protection Agency, reforming the model of service delivery and improving accountability to the Dáil.”

A Task Force was established to advise the Minister for Children and Youth Affairs in this regard. When launching this Task Force report in July 2012, Minister Frances Fitzgerald, stated that “This report proposes one of the most significant shifts in child welfare in the state’s history. It maps out a single way forward for Irish child and family services and a vision for a range of services, brought together in a manner that has never before been achieved. We are going to move from a position where child and family welfare was barely a priority, to a position where it will be the sole focus of a single dedicated State agency, overseen by a single dedicated government Department”.

This Task Force recommended that in order to achieve genuine improvements for children and families and to tackle a range of identified systemic weaknesses, the functions of the Agency should extend beyond child welfare and protection services (DYCA: 2013). However, for the purposes of this report, we will be focusing specifically on services related to child welfare and protection, including foster care services.

Functions

Under the Child and Family Agency Act 2013, the functions of Tusla are:

- supporting and promoting the development, welfare and protection of children, and the effective functioning of families;
- offering care and protection for children in circumstances where their parents have not been able to, or are unlikely to, provide the care that a child needs. In order to discharge these responsibilities, the Agency is required to maintain and develop the services needed in order to deliver these supports to children and families, and provide certain services for the psychological welfare of children and their families;
Office of the Ombudsman

- responsibility for ensuring that every child in the State attends school or otherwise receives an education, and for providing education welfare services to support and monitor children's attendance, participation and retention in education;
- ensuring that the best interests of the child guides all decisions affecting individual children;
- consulting children and families so that they help to shape the agency’s policies and services;
- strengthening interagency co-operation to ensure seamless services responsive to needs;
- undertaking research relating to its functions, and providing information and advice to the Minister regarding those functions; and
- commissioning services relating to the provision of child and family services.

**Structure**

Under the Child and Family Agency Act 2013, the Minister for Children and Youth Affairs developed a performance framework to provide the Agency with policy guidance, direction and prioritisation parameters for the preparation of its corporate plan. This is provided to the Board of the Agency. The Board of the Child and Family Agency consists of a chairperson, a deputy chairperson and 7 ordinary members appointed by the Minister. This board oversees the development of corporate strategy and sets performance objectives, amongst other functions. The Board reports to the Minister. The Board also appoints the Chief Executive Officer of the Agency in accordance with the Public Service Management (Recruitment and Appointments) Act.

The Chief Executive Officer has responsibility for the overall management of the Agency. He is assisted in the administration of his duties by the Senior Management Team. The senior management team currently consists of a Director of Finance, a Director of Human Resources, a Head of Legal Services, Chief Operations Officer, Director of Policy and Strategy, Director of Quality Assurance. The Child and Family Agency is also currently in the process of recruiting a Director of Transformation & Policy who will be part of the senior management team and will report directly to the Chief Executive Officer.

Local organisational structures are dependent on the area of service involved. As outlined above, for the purposes of this report, we will be focusing specifically on services related to child welfare and protection, including foster care services.

Child and Family Agency Child Protection and Welfare Services are divided into four regions nationally, each with a Regional Service Director. Within each region there are local areas, with a total of 17 local areas nationally. Regional Service Directors and local Area Managers have responsibility for Child Protection and Welfare services, including Alternative Care (with the exception of High Support & Special Care), Family Support and Pre-School services.

Within each local area, there are Principal Social Workers that are accountable to the Area Manager. These Principal Social Workers may manage a number of Team Leaders, who in turn may manage a team of staff, including social workers, social care workers, access workers, aftercare workers and a number of other staff.
At the end of August 2016, the Child and Family Agency had 3,570 whole time equivalent staff. Of these, 1,473 were social workers, representing an increase of 105 since establishment. It is hoped that this number will increase further in 2017.

The Child and Family Agency deals with a significant number of cases each year. In 2016, 47,399 referrals to Child Protection and Welfare Services were received of which 20,127 required an initial assessment. The average number of child protection and welfare cases open to Tusla social workers during that year was 25,650. There were 6,258 children in the care of the State in 2016.
Appendix 4

Statutory / Regulatory backdrop

It is the primary function of Tusla to “promote the welfare of children who are not receiving adequate care and protection”\(^2\). It is a positive duty which is restated in section 8(b) of the Child and Family Agency Act 2013 which provided for its establishment.

In relation to child protection, Children First: National Guidance for the Protection and Welfare of Children\(^3\)(the Guidance) provides practical detail on the role and responsibility of Tusla in dealing with child protection concerns including allegations of abuse. The Guidance which is produced by the Department of Children and Youth Affairs, deals with all aspects of child protection from recognizing and reporting child protection and welfare concerns through to the assessment and management of these reports by Tusla in conjunction with other relevant agencies. While these guidelines have not yet been placed on a statutory footing\(^4\), they are nonetheless treated as obligatory by persons with responsibility for children. The Guidance provides for mandatory reporting of concerns by certain categories of persons\(^5\).

The Guidance sets out the “key principles that should inform best practice in child protection and welfare”. These include:

- the welfare of children is of paramount importance.
- a proper balance must be struck between protection children and respecting the rights and needs of parents/carers and families. Where there is conflict, the child’s welfare must come first.
- the criminal dimension of any action must not be ignored.
- the prevention, detection and treatment of child abuse or neglect requires a coordinated multidisciplinary approach, effective management, clarity of responsibility and training of personnel in organisations working with children.

There is specific direction on the assessment and management of child protection and welfare concerns. The Guidance states\(^6\) “all child protection and welfare concerns reported to Tusla must be acted upon immediately and formally recorded, and followed up as soon as possible.

It further provides\(^7\) that Tusla should “operate standard assessment procedures for reported concerns about children”. A Practice Handbook for staff has been produced to reflect the requirements of the Guidance\(^8\).

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\(^2\) Section 3 Child Care Act, 1991, as amended
\(^3\) First published in 1999 and updated in 2011
\(^4\) Section 6 of the Children First Act 2015 which will place them on a statutory footing has not yet been commenced.
\(^5\) This too is due to be placed on a statutory footing by virtue of section 14 of the Children First Act 2015.
\(^6\) At 5.2.1
\(^7\) At 5.2.3
\(^8\) Child Protection and Welfare Practice Handbook - HSE 2011
The Guidance emphasizes that the safety and welfare of the child must remain the priority throughout the process but it is acknowledged that the assessment can often be complicated by factors outside the control of the professionals involved and does not always resemble the ordered process described in the Guidance \(^9\).

Tusla has developed its own detailed guidelines entitled “Policy & Procedures of Responding to Allegations of Child Abuse & Neglect (the Policy) \(^{10}\). This document was intended to guide staff when responding to allegations of abuse or neglect. It is informed by the statutory duty and authority of Tusla, by the Children First Guidance and by two High Court judgments\(^{11}\) in relation to fair procedures in the management of allegations of abuse. There has been no training in relation to this document provided to staff and it has been subject to a review which is not yet complete.

**MQ v Gleeson & Others, 1997 – The Barr Judgment**

This case involved a father of three against whom various allegations had been made to the local health board between 1974 and 1993. None of these allegations were put to the man until 1995 when the health board learned that he had enrolled in a childcare course which involved a placement in a children’s play center. The man was invited to a meeting where the social worker attempted to discuss the issue of the allegations with him but the man reacted badly and the meeting came to an abrupt end. The health board proceeded to notify the School who then removed him from the course.

The Judge held that the disclosure and the exclusion, had the health board taken the appropriate steps to inform itself, would have been permissible and in line with the relevant statutory duties. However, he found that the conduct of the matter by the health board amounted to a denial of the man’s right to constitution justice and fair procedures.

Before any approach was made to the school, the man should have been furnished with a list in short of the allegations and he should have been asked to respond thereto in writing or orally at a meeting. No decision should have been made about him until the applicant had been given a reasonable opportunity to make his defense to the charges against him following which the health board should carry out such further investigations as might appear appropriate in the light of information furnished by way of defense.

**PDP v A Secondary School, 2010 – The O’Neill Judgment**

This case involved a teacher in a secondary school, about whom the health board received an allegation in November 2001 of sexual abuse of a former pupil. The Gardaí were notified of the complaint in January 2002. The accused was not notified until July 2003 at which time he was provided with a written outline of 3 separate incidents which comprised the complaint. He was not informed of the identity of the child. He was invited to attend a meeting but refused until such time as he had been provided with complete information about the complaint and the proposed procedure. The health board, relying only on confirmation from the child’s counsellor that it was a validated allegation, proceeded to notify his employer of the allegations. The teacher was suspended however this was subsequently revoked but he declined to return to the school.

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\(^{9}\) At 5.2.5

\(^{10}\) September 2014

\(^{11}\) Case citations
When the Court proceedings commenced in 2006 the health board withdrew its conclusion (that he posed a serious risk to children) in its report which it sent to the school. Shortly after it indicated to the Court its intention to commence a new investigation into the allegations.

The health board was heavily criticised for its handling of the case, the Judge referred to a “litany of failures on the part of the health board to adhere to the requirements of fair procedures in its conduct of its investigation into the allegations made against the applicant”. He referred to the reliance on the counsellor’s report as an impermissible delegation of their adjudicative role in determining the validity of the abuse claims. He cited a gross delay of almost two years of near total inactivity following which the investigation was reactivated and pervious errors were persisted in and compounded.

As a result of this, the Judge ruled that if a new investigation was to be able to progress in any meaningful way respecting the norms of natural justice, then the teacher would have to be afforded the opportunity to confront his accuser who was now 22 years old. Furthermore all material on which the complaint is based would have to be released to him unequivocally for the purposes of the investigation.

The Judge cited the need to strike a balance between the man’s rights and the very serious public interest in having the health board discharge its statutory duty under the Child Care Act.

A core function of Tusla which flows from its primary duty is in relation to foster care. Tusla is responsible for the recruitment and assessment of foster carers and for the provision of ongoing training and support as well as the supervision of foster carers.

The placement of a child in foster care is governed by the Child Care Act, 1991; the Child Care (Placement of Children in Foster Care) Regulations 1995, Children Act 2001, and National Standards for Foster Care (2003). Under the 1995 Regulations, [Tusla] is required to establish one or more committees to examine applications from person wishing to be placed on a panel of approved carers. These committees are required to operate in accordance with statutory obligations and with the best practice criteria set out in the National Standards for Foster Care.

Tusla in turn has a number of policy documents which implement the National Standards and provide detailed guidance to social workers. These include, Foster Care Committee – Policy, Procedures and Best Practice Guidance (HSE, 2012), and National Policy and Procedure - Fostering Link Worker’s Role.

12 S4 provides that [Tusla] has responsibility to place, review or remove a child in foster care.
Appendix 5

Questionnaire: What Tusla staff told us.

Ombudsman Investigation: Complaint Handling in Tusla

1. In your area, how are service users/their families/others made aware of Tusla’s complaints system and policy “Tell Us”?  
   • by means of information leaflets? Yes / No  
   • via Tusla’s website? Yes / No  
   • through information contained in notices/posters located in Tusla services/premises e.g. reception areas? Yes / No  
   • through information contained in documentation provided to service users/families/others in connection with their interaction with Tusla staff? Yes / No  
   • other sources (please give details)

2. Are complaint forms readily available within your area? Do you enter all complaints on the NIMS system? Yes / No

3. How do service users and others access complaint forms and is advocacy available if required?

4. What languages are the complaint forms available in?

5. As a Complaints Officer, are you engaged solely with the processing of complaints? Yes / No

6. If you are engaged in other duties, please describe these other duties and the proportion of time spent on these duties.

7. Do you feel supported in your role as Complaints Officer – is there a forum for Complaints officers to meet, share and learn from complaint handling? Please describe.

8. As a Complaints Officer, would you apologise for any shortcomings in service delivery you have identified from your examination of the complaint? Yes / No

9. In the course of examining a complaint, would you always seek access to the case records or would you rely on the reports provided to you by Tusla staff? Please explain.

10. Does your area have criteria or guidelines on how to recognise a complaint as distinct from feedback? Yes / No

   If yes, please describe.

11. Are staff at all levels made aware of the existence and workings of the complaints system and service users rights? Yes / No

12. Does Tusla provide regular training on complaint handling? Yes / No
13. Does Tusla provide sufficient training for staff when new policies are introduced? Please describe.

14. In what circumstances would you consider mediation when dealing with a complaint? Please say if you have ever used mediation to help resolve a complaint and whether this was effective.

15. In what circumstances would you consider referring a member of staff to the governing Regulatory Body? (e.g. CORU, Nursing Board)

16. Do you always make service users aware of their right to seek a review or to go to the Office of the Ombudsman/Ombudsman for Children or pursue other avenues of review? Yes / No

17. In your view, do you think the current Tusla complaints system could be improved and if so how?

18. In your experience as a complaints handler, what do you find to be the most challenging or difficult aspect of your work?

Thank you for completing this Questionnaire
As part of the investigation process, the Ombudsman hosted a Workshop in December 2016. He invited 30 senior Complaints Officers from Tusla to attend from across a range of service areas. The purpose of the Workshop was to provide a forum for Complaints Officers to talk about their complaint handling experiences and the challenges they faced in managing them. A presentation was made about the role of the Ombudsman, case studies were discussed and a video was played from a service user’s perspective highlighting their experiences in making hospital related complaints. This was relevant as the complaints process used was similar to that in place in Tusla. In addition, the Complaints Officers were asked to complete a Questionnaire/Survey form about complaint handling in Tusla the results of which are set out under.

**Results of Questionnaire/Survey**

1. **Awareness of Tusla’s complaints policy “Tell Us”?**

   Availability of complaint forms – 90% agreed
   
   Leaflets explaining process – 50 % agreed
   
   Information on Tusla’s Website – 100% agreed
   
   Notices/Posters in Tusla premises – 50 % agreed
   
   Information about complaints process provided in correspondence - 75% agreed
   
   Other sources – feedback forms, child in care reviews, meetings with parents, home visits with children/young people, verbally over the phone.

2. **Complaints entered on the National Information Management System (NIMS)?**

   50% agreed
   
   Others had received training on NIMS but were not using it.
   
   Some said the IT system did not support easy access to NIMS and were keeping separate spreadsheets for complaints.

3. **Availability of advocacy or assistance in complaint making?**

   Some comments:
   
   - advocacy is available on request – information and links are given
   - parents with learning disabilities are encouraged to avail of advocacy services
   - social care staff provide forms and assist complainants in completing them as required
   - no advocacy services within the area but office will assist if required.

4. **Availability of complaint forms in different languages?**

   Available in Irish, English and Polish – translation is available on request
5. **Availability of designated Complaints Officers?**

Comments:

There was only one dedicated Complaints Officer for Tusla. All other Complaints Officers had additional roles and duties. Some considered that there was a need for a dedicated Complaints Officer within each Area Manager’s region.

6. **Other duties of Complaints Officers?**

Operational role as Principal Social Workers, quality standards development, FOI, computer records, garda vetting, retrospective disclosures, clerical work, reports for child in care reviews, garda/DPP liaison and parliamentary questions.

7. **Existence of a “Share and Learn” or support forum for Complaints Officers?**

The returns indicated that there was no forum for Complaints Officers to share and learn from complaint handling but most felt this would be beneficial. Some said they felt supported by their line managers and by staff in Head Office.

8. **Apology making for shortcomings identified by Complaints Officers (Bright spot)?**

Most said they would apologise except for one person who would ask the service concerned to make the apology. A small number said that legal advice could undermine or prevent an apology being made.

9. **Accessing case records or case notes when examining a complaint (Bright spot)?**

95% said they would always seek the case records and would not simply rely on the response provided by the team. One person said they would rely on the report provided by the Principal Social Worker who would have reviewed the records. Another said they wouldn’t always seek the case records due to time constraints while another would always ask the complainant for permission to access their records and would always review them.

10. **Was criteria available for recognising a complaint as distinct from feedback?**

50% agreed that criteria was available and that this information was on the client feedback forms. Others did not think criteria was available but would consider whether the complainant had been adversely affected in which case it would be regarded as a complaint.

11. **Awareness of the complaints process and service users rights among staff?**

70% agreed. Others commented that these issues were discussed at team meetings and departmental meetings but that training was essential in relation to “Tell Us”.

12. **Training provided on complaint handling on a regular basis?**

95% said that no training was provided on complaint handling but that this was due to take place in 2017. One person commented that they had not received any training until attending the Ombudsman’s Workshop. Another said that the video played as part of the Workshop was a real eye-opener on the importance of dealing with complaints and that awareness of this should be made to all staff through training and at departmental meetings.
13. **Training provided when new policies are introduced?**

99% said that no training or guidance is provided when new policies are introduced. One commented that it is up to the local area to provide training for staff. Another said that the implementation of policies is different in all areas across the services as a result of inadequate training.

14. **Use of mediation in complaint handling?**

50% said that they had never used mediation to resolve a complaint. The other 50% either had either used it or would considered using it. One person had found it useful in resolving a dispute between team members while another said it was useful when other avenues had been exhausted but failed. Another commented that it was useful in the early stages of the complaint handling if both parties agreed to it. Some other comments included the following:

- Tusla does not have a panel of approved mediators available;
- it would be useful in entrenched emotional situations;
- could be used when there is a breakdown in the relationship between the complainant and a staff member;
- would be open to it particularly if the relationship with a particular service had broken down;
- might depend on the availability of funding.

15. **Referral of staff to Regulatory Bodies?**

95% agreed that they would consider referring a staff member to the Regulatory Body if there was evidence of gross negligence, misconduct or serious disciplinary matter/breach of code of ethics. A small number did not believe that it was their function as a Complaints Officer and that this would be a matter for the Area Manager.

16. **Providing advice to service users about their right of review?**

99% agreed that they would always advise complainants of the review process or right to complain to the Ombudsman or Ombudsman for Children. This was a standard paragraph in all closing letters from Complaints Officers.

17. **Suggestions as to how the complaints process could be improved:**

- need for quicker response and processing times;
- use dedicated Complaints Officers trained in each area;
- have operational independent trained Review Officers as standard to investigate all formal reviews;
- complaints are not always prioritised amidst day to day work – need to provide training to emphasise the importance of learning from complaints;
- develop an app for young people who are technology focused to assist them in making complaints;
- learning from complaints needs to be shared within the organisation;
- complainants need advocates to frame their complaint and have people to assist them through the process;
- professional defensiveness needs to be reduced and we need to see complaints as positive learning opportunities;
adequate training in process and implementation of new complaints policy is required with more time to deal with complaints. As a Manager, I do not believe that I should be a Complaints Officer as I may not be impartial;

- need to keep the complainant informed during the process;
- need to have a clear cut off point or closing down of a complaint;
- need to provide staff with feedback when a complaint about the service has been made;
- sometimes it seems that people pass complaints on and nobody addresses the complaint, forgetting that there is a real person at the end of the letter;
- need to filter out vexatious complaints;
- complaints Officers should not investigate complaints about staff under them as this lacks impartiality;
- need to meet the complainant as soon as possible to avoid frustration and escalation of the complaint – should be standard requirement as part of the proc

18. Most challenging aspects of complaint handling for Complaints Officers:

- obtaining older records or files;
- prioritising complaints over day to day operational management;
- angry complainants looking for unreasonable resolutions;
- knock in morale and confidence when a complaint is made about you;
- finding time to deal with complaints within the timeframes;
- challenging complainants with cognitive/personality disorders;
- complexity of complaints which are usually multi-faceted;
- making balanced judgements on complaints and dealing with unreasonable or vexatious complainants;
- staff and managers too often see the complaint as a burden rather than seeing it as an opportunity to improve Tusla and our services;
- lack of support.
## Appendix 6

Complaint details (all anonymised)

<table>
<thead>
<tr>
<th>Name</th>
<th>Topic</th>
<th>Period</th>
<th>Case closure category</th>
<th>Redress provided</th>
<th>Bright spot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Smith</td>
<td>Handling of allegations of abuse</td>
<td>Tusla</td>
<td>Partially Upheld</td>
<td>Undertook to implement revised 2014 Policy</td>
<td>Written apology provided</td>
</tr>
<tr>
<td>Mr &amp; Mrs Lynch</td>
<td>Handling of historic allegations</td>
<td>HSE/Tusla</td>
<td>Upheld</td>
<td>Supervised home access granted – allegations deemed unfounded</td>
<td>Written apology provided</td>
</tr>
<tr>
<td>Mr &amp; Mrs Jones</td>
<td>Foster care- inadequate support from social workers</td>
<td>HSE/Tusla</td>
<td>Upheld</td>
<td>Acknowledgement that all issues raised were valid</td>
<td>Comprehensive written apology provided</td>
</tr>
<tr>
<td>Ms Flynn</td>
<td>Handling of historic allegations</td>
<td>Tusla</td>
<td>Upheld</td>
<td>Explanation given</td>
<td>Apology provided</td>
</tr>
<tr>
<td>Mr Brady</td>
<td>Handling of historic allegations</td>
<td>HSE/Tusla</td>
<td>Upheld</td>
<td>Social workers reminded re Barr Judgement</td>
<td>Apology provided</td>
</tr>
<tr>
<td>Mrs Kennedy</td>
<td>Foster care- voluntary care form not signed by child’s mother</td>
<td>Tusla</td>
<td>Partially Upheld</td>
<td>New Circular Issued to social workers</td>
<td>Reasonable explanation provided as to why form was not signed</td>
</tr>
<tr>
<td>Mrs Reilly</td>
<td>Foster care applicant- refused right to appeal an adverse decision and foster care guidelines not provided to complainant</td>
<td>Tusla</td>
<td>Partially Upheld</td>
<td>Given leave to appeal adverse decision. Guidelines to be provided to applicants in the future.</td>
<td>Apology provided</td>
</tr>
<tr>
<td>Ms Stone</td>
<td>Foster care- denied access to social work report for Foster Care Committee and right to independent appeal</td>
<td>Tusla</td>
<td>Partially Upheld</td>
<td>Acknowledgement of shortcomings and apology given. Changes made to processes and appeals.</td>
<td>Tusla offered to meet the complainant to apologise in person and agree a plan for moving forward.</td>
</tr>
<tr>
<td>Mrs Moore</td>
<td>Foster care- communication issues during placement and poor subsequent complaint handling</td>
<td>Tusla</td>
<td>Assistance provided</td>
<td>Tulsa undertook to review the complaint – acknowledged the shortcomings and apologised</td>
<td>Good interaction with the complainant during the review of her complaint</td>
</tr>
</tbody>
</table>
TAKING STOCK

An investigation by the Ombudsman into complaint handling and issues identified in complaints made about the Child and Family Agency (Tusla)