



Taking Stock *Executive Summary*



Oifig an Ombudsman
Office of the Ombudsman

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





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2017 Office of the Ombudsman

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(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”.¹

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.

¹ Kieran McGrath, Child Welfare Consultant, Nota News May/June 2016, “Natural Justice and Fair Procedure in Evaluating Allegations and Risk of Child Sexual Abuse”

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.



A handwritten signature in black ink, appearing to read 'Peter Tyndall', written over a white background.

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.



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