Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Guidance on an investigation into the management of allegations of child sexual abuse against adults of concern, by the Child and Family Agency (Tusla), upon the direction of the Minister for Children and Youth Affairs (the Minister)

25 April 2017

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent authority established to drive high-quality and safe care for people using our health and social care services in Ireland. HIQA's role is to develop standards, inspect and review health and social care services and support informed decisions on how services are delivered.

HIQA aims to safeguard people and improve the safety and quality of health and social care services across its full range of functions.

HIQA's mandate to date extends across a specified range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children and Youth Affairs, HIQA has statutory responsibility for:

- **Setting Standards for Health and Social Services —** Developing person-centred standards, based on evidence and best international practice, for health and social care services in Ireland.
- **Regulation —** Registering and inspecting designated centres.
- **Monitoring Children's Services —** Monitoring and inspecting children's social services.
- **Monitoring Healthcare Safety and Quality —** Monitoring the safety and quality of health services and investigating as necessary serious concerns about the health and welfare of people who use these services.
- **Health Technology Assessment —** Providing advice that enables the best outcome for people who use our health service and the best use of resources by evaluating the clinical effectiveness and cost-effectiveness of drugs, equipment, diagnostic techniques and health promotion and protection activities.
- **Health Information —** Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information about the delivery and performance of Ireland's health and social care services.

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1 Introduction

On 2 March 2017, the Health information and Quality Authority (HIQA, the Authority) was directed by the Minister for Children and Youth Affairs Katherine Zappone TD (the Minister) — in line with Section 9(2) of the Health Act 2007[1] — to undertake an investigation (the 'Investigation') under Section 9(1) of the Act.

The Minister believes that the apparent poor handling by Tusla, of information provided to it arising from the Garda Sergeant Maurice McCabe case, indicates a possible "serious risk to the health and welfare" of children. The HIQA investigation required by the Minister is to assess how local, regional and national governance arrangements in Tusla are supporting the effective management of child-sexual abuse referrals involving adults of concern (including allegations of child-sexual abuse made by adults in relation to when they were children).

The HIQA Board considered the concerns of the Minister with regard to the potential serious risk to the health and welfare of children and agreed the investigation's Terms of Reference on 8 March 2017. These Terms of Reference are contained in Appendix 1 of this document.

This guidance document has been developed to provide information to relevant parties and the public in relation to the HIQA Investigation Team's approach to carrying out this investigation.

2 Investigation approach

2.1 HIQA governance arrangements

The Investigation Team will work in accordance with HIQA's Code of Governance and Business Conduct[2] and in line with the Health Act 2007. The Investigation Team will operate to set governance and accountability arrangements in order to provide assurances to the HIQA Board about the progress, implementation and delivery of this investigation in line with the agreed Terms of Reference, as approved by the HIQA Board on 8 March 2017.

2.2 HIQA Investigation Team

The Investigation Team consists of HIQA staff members with the relevant qualifications and experience for the development, management and delivery of this investigation and resulting investigation report. These team members have been appointed by the Minister for Health as authorised persons under Section 70 of the Health Act 2007 for the purposes of conducting this investigation in line with Section 9 of the Act.

Members of the Investigation Team have extensive experience with the Authority in governance, investigations into the safety and quality of services and inspection of services. They also have expert knowledge in the field of social care and social work. In particular, the team has gained relevant experience through their roles in monitoring compliance with the nationally mandated *National Standards for the Protection and Welfare of Children*.[3]

2.3 External Advisory Group

To support the investigation, HIQA has convened an External Advisory Group with expertise in social work, child protection and children's rights. Its advice and input will reflect national and international evidence and best practice. Table 1 on the following page lists the members of the Advisory Group.

During the course of the investigation, the Investigation Team may secure additional expert advice as and when appropriate.

Table 1. External Advisory Group*

External Advisory Group of HIQA's Investigation Team	
Name	**Professional role**
Tanya Ward	Chief Executive, Children's Rights Alliance, Ireland
Andrew Lowe	Director, Lowezone Consulting, UK
Paul Morgan	Director of Children's and Young People's Services Directorate, Southern Health and Social Care Trust, Northern Ireland
Ian Sutherland	Director of Children and Adult Services, Medway Council, UK
Freda McKittrick	Assistant Director, Guardian ad Litem Service, Barnardos, Ireland
Marcella Leonard	Director, Leonard Consultancy, Northern Ireland

* The External Advisory Group has been established following completion of the declaration of interests and confidentiality statement, which is managed in line with the Authority's Policy.

2.4 Overall investigation approach

The Minister, in her letter to HIQA, indicated her belief that there is a serious risk to the health and welfare of children and has directed the Authority to investigate the management by the Child and Family Agency (Tusla) of allegations of child sexual abuse (CSA) against adults of concern.

In line with the Terms of Reference (Appendix A), the Investigation Team has developed an investigation approach plan which is informed by:

- *Children First: National Guidance for the Protection and Welfare of Children* (2011)[4]
- relevant legislation, that is to say, the Health Act 2007,[1] the Child Care Act, 1991 (as amended)[5] and the Children Act 2001[6]
- performance data[7,8] published by Tusla including the numbers of open child sexual abuse referrals by service area
- HIQA's ongoing monitoring assessments against the nationally mandated *National Standards for the Protection and Welfare of Children*
- Tusla-specific policies, procedures and guidelines gathered by HIQA, *particularly with regard to the processes in place for the man*agement of referrals of allegations of child sexual abuse by adults of concern
- the draft findings of the ongoing HIQA review of the governance arrangements that Tusla has in place in relation to child protection and welfare services
- principles of natural justice.

The investigation approach is further informed by the results of previous reviews and investigations[9, 10, 11, 12, 13, 14, 15] carried out by HIQA and by national and international best available evidence in the field.

Based on the Terms of Reference, the investigation will assess the safety, quality and standards of services provided by Tusla in relation to the referrals of allegations of child sexual abuse against adults of concern and will include:

- how local, regional and national corporate governance arrangements of Tusla are supporting the effective management of child sexual abuse referrals involving adults of concerns (including allegations of child sexual abuse made by adults in relation to when they were children)
- the effectiveness of interactions between Tusla and An Garda Síochána and other relevant third parties
- the local, regional and national arrangements, including oversight and monitoring processes in place, to ensure the timely and effective screening, assessment and management of child sexual abuse allegations involving adults of concern and allegations of child sexual abuse which occurred in the past made by adults in relation to when they were children.

In conducting this investigation, the Investigation Team will have regard for the:

- current risk to children
- workforce arrangements in Tusla
- data management arrangements in Tusla
- arrangements in place in Tusla to ensure fair procedure and due process for persons against whom allegations of child sexual abuse are made.

2.5 Investigation approach plan

An investigation approach plan will be developed. This will involve the identification of lines of enquiry, the methods used to gather evidence to inform the investigation, and the process for reporting on findings.

2.5.1 Lines of enquiry

The *National Standards for the Protection and Welfare of Children* are outcome-based Standards (each Standard describes practice that promotes the best outcome for children) that provide a framework for the development of services in Ireland that are centred on the needs of the child, protect children and promote their welfare.

There are six themes described in these Standards. The first two themes relate to the dimension of quality, the remaining four relate to the key areas of capacity and capability. Lines of enquiry were designed in line with the investigation's Terms of Reference and the *National Standards for the Protection and Welfare of Children* to guide the approach and provide a framework for the selection, gathering and analysis of evidence.

The lines of enquiry of this investigation were framed around the National Standards and represent a series of criteria to assess the arrangements in place in relation to the safety, quality and governance of care provided by Tusla. They primarily focus on four of the themes of the National Standards, which reflect the essential components of a high-quality, safe child welfare and protection service, and encompass the required capacity and capability of the service provider to deliver such services.

These themes are outlined as follows:

Dimension of quality

- Safe and Effective Services

Capacity and capability

- Leadership, governance and management
- Use of resources
- Use of information.

The lines of enquiry under each of these themes have been developed to reflect the investigation's Terms of Reference and to provide a framework for the sampling, gathering and analysis of evidence.

Furthermore, they will enable an examination of Tusla's capacity and capability to deliver high-quality, safe and effective services for children and families at local, regional and national level, specifically in relation to the management of allegations of child sexual abuse against adults of concern.

2.5.2 Method of enquiry

Using information obtained by HIQA through the methods outlined above, the Investigation Team took a risk-based approach in relation to prioritising Tusla service areas to visit and cases to review. A representative sample of approximately 50% of service areas will be identified for on-site visits.

The methods of enquiry are described in more detail on the following pages.

Information review and evaluation

In line with the Terms of Reference of the investigation, the lines of enquiry and section 73 of the Health Act 2007, the Investigation Team will review and evaluate information through documentation and data review, interview, group meetings and case-record review.

Documentation and data

In accordance with the Terms of Reference of the investigation and in addition to information gathered previously, as outlined in section 2.4 above, the Investigation Team will issue documentation and data requirements to Tusla prior to and during the investigation.

Case-record review

Through case-record review, the Investigation Team will assess the quality, safety and effectiveness of the operational arrangements in place to ensure the effective management of allegations of child sexual abuse against adults of concern, and how the risks relating to this aspect of service provision is being assessed and managed by Tusla.

Service provider interviews

Interviews will be conducted with relevant persons locally, regionally and nationally. These interviews will clarify issues identified by the Investigation Team during the documentation and data review.

Prior to each interview, each interviewee will receive a letter of notification of interview from the Investigation Team.

Interviews will be conducted by two members of the Investigation Team and will take approximately 60–90 minutes. Service-provider interviews will be recorded electronically. Interviewees will receive an audio-recording of their individual interview.

Information provided at interview will not be attributed to any individual in the final report. The investigation team may require additional information and may request further interviews with individuals at a later stage.

Focus group meetings

Focus group meetings will be carried out with Tusla staff and representatives of relevant external agencies, as required. These focus groups will inform the Investigation Team of Tusla's compliance with Children First (2011) and relevant internal policies and procedures.

Capturing personal experience

In order to overcome the inherent challenges to capturing a broad range of individual experiences, the Investigation Team will take a case-record review approach. This involves a review of aspects of select cases which demonstrate how the rights of individuals are promoted and their needs have been met by Tusla.

In adopting this methodology, the Investigation Team will assess the quality and safety of the operational arrangements in place to ensure the effective screening, assessment and management of allegations of child sexual abuse allegations against adults of concern, and allegations of child sexual abuse which occurred in the past made by adults in relation to when they were children.

In addition to information gathered through the case-record review process, there is an already established system whereby members of the public with concerns about services can make direct contact with HIQA. Information provided by members of the public using this system will be reviewed and if appropriate considered as part of the investigation.

Risk management and escalation

During the course of this investigation, the Investigation Team may at any stage identify specific issues that they believe may present an immediate and or potential serious risk to the health or welfare of children. In line with HIQA policy, these risks will be assessed and then escalated with the necessary correspondence issued to the service provider and or Minister for Children and Youth Affairs.

Investigation draft report and due process

The Investigation Team will provide a copy of the relevant excerpt(s) of the confidential draft report, on an individual basis or in a representative role, to relevant senior managers in Tusla, other professionals and agencies, interviewed by the investigation team or whose role or decisions are featured in the draft report.

The Investigation Team will take due consideration of the rights of the individuals involved in relation to privacy and confidentiality, dignity and respect, due process and natural and constitutional justice.

Those who will receive a copy of a relevant excerpt or excerpts will be invited by HIQA to offer, within 10 working days of receipt, feedback and commentary specific to the draft report excerpt or excerpts. Every comment received will be carefully considered by the Investigation Team and HIQA prior to the publication of this report.

2.6 Findings and report

The investigation involves the review and evaluation of information derived from multiple sources. Based on the evidence gathered, and the due process outlined above, the investigation report and recommendations will be published following the approval of the Board of HIQA.

As with any investigation undertaken by the Authority, and in the interest of a fair and thorough investigation, HIQA does not envisage making any public comment on the conduct or progress of the investigation until the investigation has been concluded and its report published.

References[±]

[1] Health Act 2007. Dublin: The Stationery Office; 2007. Available online from: http://www.irishstatutebook.ie/2007/en/act/pub/0023/index.html.

[2] Health Information and Quality Authority. *Code of Governance and Code of Business Conduct*. Dublin: Health Information and Quality Authority; 2014. Available online from: https://www.hiqa.ie/sites/default/files/2017-01/Code-of-Governance-and-Conduct-2014.pdf

[3] Department of Children and Youth Affairs. *Children First: National Guidance for the Protection and Welfare of Children.* Dublin: Department of Children and Youth Affairs; 2011. Available online from: https://www.dcya.gov.ie/documents/Publications/ChildrenFirst.pdf

[4] Health Information and Quality Authority. *National Standards for the Protection and Welfare of Children.* Dublin: Health Information and Quality Authority; 2011. Available online from: https://www.hiqa.ie/sites/default/files/2017-01/Child-Protection-Welfare-Standards_2.pdf

[5] Child Care Act, 1991 (as amended). Dublin: The Stationery Office; 1991. Available online from: http://www.irishstatutebook.ie/eli/1991/act/17/enacted/en/print.html

[6] Children Act, 2001. Dublin: The Stationery Office: 2001. Available online from:

http://www.irishstatutebook.ie/eli/2001/act/24/enacted/en/html

[7] Child and Family Agency (Tusla). *Quarterly Management Data Activity Report.* Dublin: Child and Family Agency (Tusla); 2016. Available online from: http://www.tusla.ie/uploads/content/Tusla_Management_Data_Report_Quarter_4_2016.pdf

[8] Child and Family Agency (Tusla). *Monthly Performance and Activity Data.* Dublin: Child and Family Agency (Tusla); 2017. Available online from: *http://www.tusla.ie/uploads/content/Tusla_Monthly_Performance_and_Activity_Data_January_2017.pdf*

[±] All online references were accessed at the time of preparation of this guidance document. Please note that website addresses may change over time.

[9] Health Information and Quality Authority. *Report of the investigation into the safety, quality and standards of services provided by the Health Service Executive to patients in the Midland Regional Hospital, Portlaoise*. Dublin: Health Information and Quality Authority; 2015. Available online from: https://www.hiqa.ie/sites/default/files/2017-01/Child-Protection-Welfare-Standards_2.pdf

[10] Health Information and Quality Authority. *Report of the Investigation into the safety, quality and standards of services provided by the Health Service Executive to patients, including pregnant women, at risk of clinical deterioration, including those provided in University Hospital Galway, and as reflected in, the care and treatment provided to Savita Halappanavar.* Dublin: Health Information and Quality Authority; 2013. Available online from: http://www.hiqa.ie/healthcare/focus-quality-safety/investigations/galway.

[11] Health Information and Quality Authority. *Report of the investigation into the quality, safety and governance of the care provided by the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital (AMNCH) for patients who require acute admission*. Dublin: Health Information and Quality Authority; 2012. Available online from: http://www.hiqa.ie/publications/report-investigation-quality-safety-and-governance-care-provided-adelaide-and-meath-hos.

[12] Health Information and Quality Authority. *Report of the investigation into the quality and safety of services and supporting arrangements provided by the Health Service Executive at Mallow General Hospital*. Dublin: Health Information and Quality Authority; 2011. Available online from: http://www.hiqa.ie/publications/report-investigation-quality-and-safety-services-and-supporting-arrangements-provided-h.

[13] Health Information and Quality Authority. *Report of the investigation into the quality and safety of services and supporting arrangements provided by the Health Service Executive at the Mid-Western Regional Hospital Ennis*. Dublin: Health Information and Quality Authority; 2009. Available online from: http://www.hiqa.ie/publication/report-investigation-quality-and-safety-services-and-supporting-arrangements-provided-hs.

[14] Health Information and Quality Authority. *Report of the investigation into the circumstances surrounding the provision of care to Rebecca O'Malley, in relation to her symptomatic breast disease, the Pathology Services at Cork University Hospital and Symptomatic Breast Disease Services at the Mid Western Regional Hospital, Limerick*. Dublin: Health Information and Quality Authority; 2008. Available online from: *http://www.hiqa.ie/publication/investigation-circumstances-surrounding-provision-care-rebecca-omalley-relation-her-symp*.

[15] Health Information and Quality Authority. *Report of the investigation into the provision of services to Ms A by the Health Service Executive at University Hospital Galway in relation to her symptomatic breast disease, and the provision of Pathology and Symptomatic Breast Disease Services by the Executive at the Hospital*. Dublin: Health Information and Quality Authority; 2008. Available online from: http://www.hiqa.ie/publication/investigation-report-pathology-service-and-symptomatic-breast-disease-service-university.

Terms of Reference

Section 9 Health Act 2007 (the "Act") Investigation

Investigation into the management of allegations of child sexual abuse (CSA) against adults of concern, by the Child and Family Agency "Tusla", upon the direction of the Minister for Children and Youth Affairs (the "Minister")

1. Direction of Minister to undertake a Section 9 investigation

On 02 March 2017 the Authority was directed by the Minister (pursuant to the Minister's power to do so under Section 9(2) of the Act) to undertake an investigation (the "Investigation") under Section 9(1) of the Act. The Minister believes that the apparent poor handling by Tusla of information provided to it, arising from the Garda Sergeant Maurice McCabe case, indicates a possible "serious risk to the health and welfare" of children. The Investigation required by the Minister is to be "of Tusla's national practices in the handling of referrals of allegations of sexual abuse which involve adults of concern".

2. Scope of Investigation specified by the Minister

In particular the Minister directed the Authority to provide in its investigation an assessment of the handling by Tusla of such referrals, at national and area level, having regard to the following areas:

- Current risk to children
- Fair procedure and due process for persons against whom allegations are made
- engagement between Tusla and An Garda Síochána, including monitoring or co-ordination of efforts
- An assessment of the number and mix of skilled and experience staff involved and if this is sufficient for the purpose
- Allegations being managed in a timely manner and an indication of reasons where they were not
- Management and control of information and data, both received and generated by Tusla.

3. Exclusions from Scope of the Investigation as directed by the Minister

The Minister has specifically directed that the Authority, in its Investigation, should take all necessary steps to avoid the potential for overlap with the Tribunal of Inquiry established to inquire into certain protected disclosures, arising from the protected disclosures made by Garda Sergeant Maurice McCabe (the "Tribunal"). In particular the Minister has directed that any files "relating to allegations of child abuse that come within the terms of reference of the Tribunal and, in particular, files concerning allegations of abuse of children against members of An Garda Síochána, are formally excluded from the Authority's investigations".

The Minister has informed the Authority that the Ombudsman is also currently considering some complaints about retrospective cases involving adults of concern and their handling by Tusla. Tusla has informed the Authority that the Office of the Data Protection Commissioner is conducting an investigation on the overall governance of data protection throughout Tusla.

Utilising the National Standards for the Protection and Welfare of Children, the investigation team will examine the effective management of information and the availability of adequate resources. However, the investigation will not include a comprehensive assessment of the number and mix of skilled and experienced staff involved nor will it include assessment of Tusla's compliance to the Data Protection (Amendment) Act 2003.

4. Specific Terms of Reference of the Investigation

In conducting this Investigation, the Authority will investigate and assess against nationally mandated standards and evidence based practice how local, regional and national governance arrangements in Tusla, are supporting the effective management of child-sexual abuse ("CSA") referrals involving adults of concern (including allegations of CSA made by adults in relation to when they were children). This Investigation will be further to, and take account of, the existing information available to the Authority from its existing inquiries as part of its monitoring function under Section 8(1) (c) of the Act in relation to child protection services provided by Tusla.

The Investigation will be carried out on the basis of the following Terms of Reference:

(a) To carry out an Investigation into the safety, quality and standards of the services provided by Tusla in relation to referrals of allegations of child sexual abuse with particular regard to the areas identified by the Minister (and as set out in paragraph 2 above).

(b) In particular to investigate and assess how local, regional and national corporate governance arrangements provided by Tusla are supporting the effective management of CSA referrals involving adults of concern, including allegations of retrospective CSA.

(c) In particular to investigate and assess the efficacy of bilateral interactions between Tusla, An Garda Síochána and all relevant third parties.

(d) The Investigation will specifically include an assessment of the operational arrangements, including the oversight and monitoring processes in place, to ensure the timely screening, assessment, and management of:

A. CSA allegations involving adults of concern; and

B. Allegations of CSA which occurred in the past made by adults in relation to when they were children.

5. Recommendations and Reporting

If, in the course of the Investigation, it becomes apparent that there are reasonable grounds to believe that there are further or other serious risks to any children or persons receiving services, the Investigation Team may recommend to the Authority and/or the Minister that these terms be extended to include further investigation or that a new investigation should be undertaken, as appropriate.

The Authority shall, prepare a report of the findings of the Investigation and make national recommendations pertaining to Tusla's management of CSA allegations referred to it, to the extent that the Authority considers appropriate. The report will be submitted to the Board of the Authority for approval. This report will be published in order to promote safety and quality in the provision of child protection services for the benefit and welfare of the public.

6. This Investigation will be carried out in accordance with Section 9 and all other relevant provisions set out in the Act. The Investigation will be conducted by an Investigation Team appointed and authorised by the Authority in accordance with Part 9 of the Act. The Team will carry out the Investigation and may exercise all of the powers available to it or its personnel under the Act, particularly those powers set out in Part 9 of the Act, including rights of entry, its rights to inspect premises, records and/or documents and its rights to conduct interviews and rights to require explanations in relation to documents, records or other information. In addition, the Authority (with appropriate Ministerial approval and in accordance with the Act, where required) may engage advisors as it considers necessary in the undertaking of this Investigation.

These Terms of Reference were approved by the Board of the Authority on 08 March 2017.

Published by the Health Information and Quality Authority.

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