An investigation into Stewarts Hospital and the Health Services Executive into the administrative policies and procedures followed in relation to an incident where a child with physical and learning disabilities was slapped by a member of hospital staff while in respite care at Stewarts Hospital

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Contents

Overview

In July 2008 the Ombudsman for Children became aware of a case in which a staff member of Stewarts Hospital had been dismissed on the grounds of gross misconduct for slapping a child with physical and intellectual disabilities in respite care, following an internal hospital inquiry. The incident in question occurred in July 2006 when a child in respite care in Stewarts Hospital was slapped by a member of staff. This incident resulted in an internal investigation following which the staff member was dismissed. This action was appealed by the staff member concerned to the Employment Appeals Tribunal and the Tribunal determined that the dismissal had been unfair and that the staff member should be reinstated as an employee of Stewarts Hospital.

The Ombudsman for Children may initiate investigations of her own volition. On the basis of the information about this case put into the public domain, the Office contacted Stewarts Hospital in 2008 to undertake a preliminary examination into the matter. Given the importance of the issues raised by this incident a decision was taken to launch a full investigation into the administrative policies and procedures followed by Stewarts Hospital in relation to this incident. As this investigation progressed it became necessary to include the HSE, as the statutory body with responsibility for child protection, in the remit of the investigation.

The Ombudsman for Children took the decision to launch an investigation into the administrative actions of Stewarts Hospital and the Health Services Executive (HSE) for a number of reasons including to determine:

- Whether the best interests of the child had been considered at all stages of the process
- How welfare concerns or potential risks to children in Stewarts Hospital were being dealt with
- How Stewarts Hospital and the HSE had reacted to the incident
- The extent to which these organisations are guided and supported by legislation and policy
- The level of monitoring that existed in relation to the incident and how the reinstatement of the employee had been handled
- How the competing interests of the employee and the child were addressed
- Whether the child concerned had been adversely affected as a result of the incident and the subsequent actions

Background to the Case

The child at the centre of this investigation was 14 years of age at the time of the incident. This child had been attending Stewarts Hospital since 1998 and received respite care at the facility every four to six weeks. This child presents with multiple disabilities, uses a manual wheel chair and has a severe learning disability.

- An incident occurred at Stewarts Hospital between a member of staff and a child in respite care. The reporting of the incident through the hospital's internal structure led to a child protection referral being made to the HSE by telephone.
- The parents of the child were informed of the allegation and were advised that the hospital would be conducting an internal investigation into the matter.
- Stewarts Hospital wrote a brief formal letter to the HSE. This letter advised of the allegation of physical abuse which had been made and confirmed that a copy of the internal investigation report would be provided to the HSE once it was completed.
- The HSE wrote to Stewarts Hospital and confirmed that an internal enquiry was the most appropriate way to proceed. The letter further assumed that any possible immediate child protection risks had also been addressed. The offer for further advice and guidance on the matter, if required, was made by the HSE to Stewarts Hospital and the letter concluded that the HSE would await receipt of the report in due course.

Stewarts Hospital also took a number of steps, in accordance with the *Trust in Care* policy document, including placing the staff member at the centre of allegations on leave for the duration of this internal investigation.

In April 2007 the internal investigation concluded and found that the staff member at the centre of allegations had struck the child. Following this, the decision was made to remove the staff member from employment. An appeal was made to the Chief Executive of the Hospital who upheld the decision and following this an appeal was lodged with the Employment Appeals Tribunal.

In May 2008 the Employment Appeals Tribunal acknowledged that the hospital involved had an exceptional duty of care to the vulnerable clients in its care and that it had properly investigated an allegation of misconduct against the staff member. However, the tribunal unanimously found that the hospital acted disproportionately in dismissing the staff member and ordered that they be reinstated.

The hospital sought legal advice as to whether to appeal the matter to the High Court but the costs associated with such an action were prohibitive.

Investigation and Findings

The OCO investigation focused on three core areas:

1. The administrative actions of Stewarts Hospital and the HSE with respect to its handling of the child protection matter of July 2006
2. The relevant policy, procedures and legislation which provide guidance and governance on these matters
3. The possible adverse affect on the child as a result of those administrative actions

As part of this investigation, meetings were held with Stewarts Hospital and the HSE, and all files held on the matter including correspondence between the two parties was reviewed. In addition, policies and guidelines which were used by these parties were also examined.

Due to the child having a learning disability resulting in severe communication difficulties the parents of the child concerned were considered to be the strongest advocates for the child and were also consulted.

During the investigation, the OCO determined a number of key facts:

- The internal employer investigation report which was completed in April 2007 was not forwarded as agreed by the hospital to the HSE until February 2009.
- Delays in the initiation and subsequent completion of the investigation were not communicated to the HSE.
- The HSE kept the file “open” on this case but following the initial report and HSE response in July 2006 the HSE did not make further contact with the hospital until June 2009 with respect to its follow up on the child protection referral. The HSE has indicated that telephone contact was attempted in October 2007 but was unsuccessful.
- The Employment Appeals Tribunal determination which was provided by the hospital to the HSE in June 2008 refers to the findings of that report. However, the HSE did not request either a copy of the report or determine whether they had a further role to play in the matter.

In addition, the Ombudsman for Children’s Office was advised by the parents of the child concerned that they had been advised by Stewarts Hospital that they would be kept up to date on developments in the matter, but that this did not happen. In the case of the Employment

Appeals Tribunal process, the parents only became aware of the conclusion of the tribunal process when a family friend recognised the circumstances as described in a newspaper article and contacted them.

The parents of the child further advised that it was only on the reading of the Employment Appeals Tribunal determination and related newspaper articles at that time that they became aware of the severity of the matter, where it was reported that their child was physically struck a number of times.

The parents of the child are of the view, and communicated this view to the Ombudsman for Children's Office that the lack of communication from the hospital, along with not knowing what the internal investigation found, led to a situation whereby they were unable to advocate effectively on their son's behalf.

The Ombudsman for Children is of the view that the consideration of the child's best interests at all times would have been best served if Stewarts Hospital had provided the information as required and directly sought further HSE input on the matter, and if the HSE had maintained a concurrent oversight and enquiry role into the circumstances of the matter.

The Ombudsman for Children also finds that the best interests of the child in the overall process were not sufficiently considered having regard to their welfare and right to participation as the child's parents were not given sufficient opportunity to be involved in the process.

The Adverse Effect on the Child

It is clear from reviewing the internal report that the incident in July 2006 hurt the child involved and was very upsetting. In full consideration of the circumstances which are set out in the internal report, the Office is of the view that the physical punishment or striking of a vulnerable child with intellectual disabilities as occurred in this instance is an example of treatment of a child that is:

- Degrading
- An affront to the child's dignity
- An infringement of the child's basic human rights

The evidence of the witness statements also provides detail of the upset that was caused on other children present in the room.

This Ombudsman for Children's Office is also of the view that the adverse effect of such an incident impacts disproportionately on children with intellectual disabilities who are particularly vulnerable and may have difficulties communicating and verbalising the hurt that may have been caused.

The Ombudsman for Children's Office finds that the child involved was entitled to a situation whereby the examination of such a serious incident would occur in an overall system which would also consider their best interests. This consideration was not limited to just ensuring that the employee would not be in further contact with the child. The consideration of the child's interests should not have been suspended while the employment process progressed only for those issues to resurface at the outcome of the employment process.

As a result of the lack of involvement of the child's parents, the Ombudsman for Children's Office finds that the best interests of the child in the overall process were not sufficiently considered having regard to their welfare and right to participation in a process which would directly affect them.

About the Internal Investigation Report

The OCO is of the view that the physical punishment or striking of an intellectually disabled child is a serious welfare concern for both the organisation involved and the HSE. There is also an additional concern that the witness statements which formed part of that internal investigation contain details of an element of a deliberate punitive physical sanction on the child in that position.

Having considered both the contents of the report and the contention that the hospital was concerned that the employee allegedly did not take responsibility for the incident, and was not willing to engage in reflective discussion on what had happened, the Ombudsman for Children's Office finds that there were significant child protection and welfare concerns existent at the time of the referral and on reinstatement.

Overall this Office finds that the HSE, in not having sight of all the information throughout the period of July 2006 up until February 2009, did not afford itself the opportunity to adequately consider the child protection and welfare issues that were being addressed in the hospital with respect to its role as the statutory agency with responsibility for the assessment and management of child protection concerns.

While the Ombudsman for Children's Office understands and accepts the assertion of the HSE that the reinstatement of the staff member was outside of the control and remit of the Child

Protection Services of the HSE as the employment appeal process is a completely separate legal process, it remains the view that an overall approach which primarily deals with the incident as an employment issue to the exclusion of the HSE does not adequately ensure that the best interests of the child are considered.

About the Employment Appeals Process

It appears that the Employment Appeals process which occurred in this instance did not set out to further substantiate the allegation which had already been determined by the internal employment investigation. Rather, it sought to determine whether the employer's action in dismissing the staff member was fair.

In determining this particular issue, it had regard to the employment history and previous conduct of the staff member, character references from other co-workers and the actions of the Hospital itself. The lack of consideration of the views or interests of the child in any particular section of an employment law process may be singularly justifiable when considered in the context of its core function, i.e. adjudications on employee and employer actions.

The Ombudsman for Children's Office, however, finds that it is the absence of any other independent oversight or monitoring of the situation, coupled with a lack of effective communication between the HSE and Stewarts Hospital, that has resulted in the acceptance, *tacit or otherwise*, of an overall administrative approach whereby the rights of an employee being dealt with on an entirely separate basis become disproportionately prioritised above the child's rights and best interests.

Recommendations

The Ombudsman for Children, following an investigation, aims to make recommendations which are fair and constructive for all parties concerned. In making these recommendations, the Office has regard to the best interests and rights of the child at the centre of this investigation. In making recommendations, the Ombudsman for Children is also cognisant of her statutory obligation to promote the rights and welfare of children.

As per Section 13(3) of the Ombudsman for Children Act, 2002, following this investigation and its findings, the Ombudsman for Children recommends that the following actions take place:

1. Stewarts Hospital to revise existing policy and administrative procedures to ensure that undertakings with respect to the provision of information to the HSE in respect of child protection referrals are complied with in a timely manner and independently of any employment disciplinary process that may be ongoing.

2. Stewarts Hospital and the HSE to revise their administrative policy and procedure to ensure an effective liaison occurs between them following a child protection referral. Such effective liaison is to include adequate documenting and record keeping in an effort to ensure that the matter is monitored and acted upon.

3. Stewarts Hospital to revise its child protection policies to ensure that adequate communication occurs with the parent(s)/ guardians of a child when an internal employment investigation into physical abuse or maltreatment is initiated which involves that child.

4. Stewarts Hospital and the relevant HSE area separately or otherwise to offer to meet with the parents of the child to explain in full the steps that were taken following the child protection referral and to offer further explanation and clarity with respect to their individual roles in this matter to date.

5. The HSE to directly address the administrative issues highlighted by this Office whereby a child protection referral of an allegation of physical abuse within an organisation was allowed to be examined and concluded exclusively as an employee misconduct matter without any effective HSE intervention, involvement or oversight in the matter.

6. The HSE to take administrative steps to ensure that organisations providing services to children, that it provides funding to, are fully compliant with any HSE initial assessment decisions which are made on foot of child protection referrals which are received. The HSE to ensure that initial referrals made contain all relevant information available on the reported incidents.

7. The HSE to revise the policy and practice of awaiting the outcome of internal employee/employment disciplinary processes in instances of alleged physical abuse in organisations providing care for vulnerable children with intellectual disabilities before determining its role in the matter. In cases of this kind, the HSE to consider whether a concurrent approach to any internal investigation is warranted to ensure a timely and effective involvement in incidents whereby:
   - the specific purpose of the employment internal investigation seeks to make a determination on whether physical abuse occurred; and
   - the employment process will not involve communication with or consideration of the views of the parent/ guardian or the child.

8. The Minister for Children to take all necessary steps to ensure the independent inspection of all residential institutions for children with intellectual disabilities in accordance with the provisions of the Ryan Report Implementation Plan. Those measures taken should ensure that respite services for children within residential centres are also subjected to independent inspection. The Ombudsman for Children's Office will continue to seek that outcome through all possible means and functions within this Office.

9. The HSE, in light of this investigation, to reconsider the content of the internal investigation report in its entirety to determine whether there is any further follow up required with Stewarts Hospital and to act upon same.

10. In the absence of independent inspection and having regard to the information elicited through the internal investigation, Stewarts Hospital to review the full content of the internal investigation report in its entirety to satisfy itself that the training needs of staff are appropriately identified and addressed in implementing existing policy in relation to how children are to be treated in the hospital.