

**Commission of Investigation
(Certain matters relative to a disability service in
the South East and related matters)
("the Farrelly Commission")
Final Substantive Report – Volumes 3, 4, 5, 6 and
Commission of Investigation statement on Part X
of the Terms of Reference**

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CHAPTER 1 - Introduction to Care Volume

1. Introduction

- 1.1 One of the most critical investigative tasks for the Commission in Phase One of its work was to establish the facts about the care provided by Family X to Grace from 1989 (when, at the age of 10, the SEHB placed her in foster care with Family X) until 2009 (when, aged 30, the HSE removed her to a residential placement). This task encompassed that of establishing the facts on the evidence to the Commission with respect to Grace's care and "*in particular whether, and the extent to which, Grace suffered any abuse whatsoever*" while in the care of Mr. and Mrs. X, as well as establishing where any abuse identified by it had occurred and by whom it had been perpetrated. The Commission's findings on the outcome of its comprehensive investigation of these questions in the Terms of Reference will be reported in this Volume.
- 1.2 This Introductory Chapter is written having regard to Chapters 1 (Introduction) and 2 (Methodology) of the Commission's First Substantive Interim Report and Chapters 9 and 10 of its Second Substantive Interim Report and is to be read in conjunction with those chapters. For the most part, therefore, it is not required to repeat here what is contained in those earlier chapters.
- 1.3 The Commission has undertaken substantial investigations into the overall care and treatment of Grace, including into questions of whether she suffered any abuse. This Volume of its Final Substantive Report now incorporates a number of chapters, each of which examines a specific aspect of Grace's care and attendant potential type of abuse as provided for under the Commission's Terms of Reference (detailed below).¹
- 1.4 The facts that emerged from the extensive evidence relevant to the Commission's consideration of Grace's care and the question of whether she suffered abuse are set out throughout the various chapters of this Volume. On occasion, there is necessary and unavoidable duplication throughout the Volume where the relevance of the evidence may vary depending on the context.

¹ The Terms of Reference are, for convenience, appended to the Preface to the Final Substantive Report.

2. Scope

- 2.1 This Volume reports on the overall care and treatment of Grace and, in accordance with the Terms of Reference, *“in particular whether, and the extent to which, Grace suffered any abuse whatsoever, [from 1989 to 17th July, 2009 inclusive].”* The Terms of Reference further required that: *“[t]he facts relating to abuse should be established regardless of whether the alleged abuse occurred within the family home, or in another location, and whether the alleged abuser(s) was/were a member of Family X or any other person(s).”*
- 2.2 The Commission was directed to investigate and to establish the facts with respect to the matters set out at Parts III to IX of the Terms of Reference set for the Commission. The Terms of Reference relevant to the care of Grace from the time that she was placed in the care of Family X in 1989 until she was transferred to residential care on 17th July, 2009 were as follows:
- (i) Term of Reference V. a) required the Commission to establish the facts relating to the *“care received by Grace, in particular whether, and the extent to which, Grace suffered any abuse whatsoever, during the years 1989 to 1996 before Grace reached the age of 18. The facts relating to abuse should be established regardless of whether the alleged abuse occurred within the family home, or in another location, and whether the alleged abuser(s) was/were a member of Family X or any other person(s).”*
 - (ii) Term of Reference VIII. a) required the Commission to establish the facts relating to the *“care received by Grace, in particular whether, and the extent to which, Grace suffered any abuse whatsoever, from the date of her 18th birthday in 1996 to 17th July 2009 inclusive. The facts relating to abuse should be established regardless of whether the alleged abuse occurred within the family home, or in another location, and whether the alleged abuser(s) was/were a member of Family X or any other person(s).”*

3. Abuse

3.1 The term “*abuse*” was defined in the Terms of Reference to mean:

“any act, or failure to act, which results in a breach of a vulnerable person’s human rights, civil liberties, physical and mental integrity, dignity or general well-being, whether intended or through negligence, including sexual relationships or financial transactions to which the person does not or cannot validly consent, or which are deliberately exploitative. Abuse may take a variety of forms.”

3.2 The Terms of Reference defined “*vulnerable adult*” as “*an adult who may be restricted in capacity to guard himself / herself against harm or exploitation or to report such harm or exploitation. Restriction of capacity may arise as a result of physical or intellectual impairment. Vulnerability to abuse is influenced by both context and individual circumstances.*”

3.3 Reference will be made throughout this Volume to the statutory providers of health service at different times. The Health Service Executive is generally referred to as “the HSE”. The South Eastern Health Board is generally referred to as “the SEHB” or “the health board”.

4. Structure of the Volume

4.1 This Volume reports upon Grace’s care and treatment and the question of whether she suffered any abuse over the 20 year period when she was in the care of Family X. The Commission’s findings on the factual questions concerning the standard of care and treatment that Grace received and whether she suffered abuse are addressed in separate chapters within this Volume. The Commission considers that the wide scope of the definition of “*abuse*” set out in its Terms of Reference is comprehensively addressed under the chapter headings set out below:

- Chapter 2: Physical Abuse;
- Chapter 3: Neglect;
- Chapter 4: Sexual Abuse;

- Chapter 5: Financial Abuse; and
- Chapter 6: Emotional Abuse.

4.2 The impact upon Grace's physical health and well-being as a result of her removal into a residential placement in July, 2009 was also an issue that was relevant when considering the evidence with respect to Grace's care. This is reported extensively in Chapter 4 in the context of the examination of Grace's behaviours and presentation following her move into that placement in July, 2009.

4.3 The Commission was mindful throughout its investigations into Grace's care and the question of abuse to examine each discrete aspect of care. At times it was necessary to have regard to the interconnections and overlap in the relevant evidence between each discrete area of investigation.

5. Grace

5.1 The issue of Grace's care as a profoundly vulnerable and highly dependent adult and the concern as to whether she suffered any abuse and, if so, where, when and by whom, were issues of significant public concern at the core of the suite of Terms of Reference set for the Commission's inquiries. Grace is non-verbal and was unable to communicate on any of the issues under investigation.

5.2 The nature of the inquiry conducted by the Commission into Grace's care and the question of whether she was ever subjected to abuse over a 20-year period, of necessity intruded deeply into her personal and private life. The nature of the issues raised as having caused concern about Grace's welfare and the concerns and hypotheses of abuse, were such that every aspect of her day-to-day life fell for consideration. Having regard to Grace's level of intellectual disability, she was and remains entirely unaware of the work of the Commission or of any inquiry into the circumstances of her life.

5.3 Grace's physical presentation and appearance, her abilities and disabilities, behaviours and habits, bodily functions and matters of intimate care have all been opened to scrutiny and analysis. All of Grace's medical records, psychological and psychiatric assessments, her personal history, her personality, relationships with

others, likes and dislikes, have necessarily been taken into consideration in an investigation of this kind.

- 5.4 Notwithstanding that, such scrutiny was required in fulfilling the Commission's mandate to inquire into these matters of significant public concern and, in particular, to establish the facts on the questions about abuse.
- 5.5 The question as to whether or not Grace was subjected to abuse was a matter of vital importance in the true telling of her life story. That was the case even though Grace herself had no understanding of the Commission's work or of the outcome of its investigations. The establishment of the facts as to whether she was subjected to abuse was a matter of importance to her dignity and integrity as a person.
- 5.6 This was also a matter of profound importance to persons against or about whom allegations had been made or suspicions aired. In this regard, the Commission was mindful that the questions as to whether Grace suffered abuse and the related matters set for investigation involved matters that potentially gravely impacted upon the reputations of such persons, in particular persons forming part of the Family X household. In gathering the evidence and establishing the facts on this matter, as with each part of its investigations, the Commission has had regard to the fundamental requirements of fair procedures to all parties engaged with or affected by its work.

6. Context

- 6.1 The investigation of events concerning the question of whether Grace suffered abuse, and, if so, where and when and by whom, could not be undertaken without taking into account the reality of Grace's life and the lives of her carers.
- 6.2 Contextual matters relevant to Grace's characteristics, behaviours, presentation and challenges are set out in Chapter 2 and are referred to, where applicable, in each of the chapters of this Volume. These derived from the extensive evidence that emerged throughout the course of the Commission's investigations and assist in understanding Grace's life and circumstances when viewing the concerns that arose as to whether she was subjected to abuse.

- 6.3 Reports and assessments concerning Grace from her early childhood and up to shortly before her placement by the SEHB into foster care with Family X have been reported in the First Substantive Interim Report. These reports, which detail the profound level of Grace's disabilities, and her presentation and behaviours at that time, should be read with this Volume as they provide significant background context. The extent of Grace's care needs and her vulnerabilities associated with her profound intellectual disabilities has been reported in the Commission's First and Second Substantive Interim Reports.

7. Witnesses and the evidence

- 7.1 Grace was the person at the centre of the Commission's investigation. Owing to her profound mental disability and lack of speech, evidence from Grace was not available to the Commission. The facts pertaining to her life and the matters which the Commission was required to investigate pursuant to its Terms of Reference therefore had to be established through hearing the evidence of other persons and through considering the records and documentation which were disclosed to the Commission over the course of its investigations.
- 7.2 The evidence relevant to the matters reported in this Volume was gathered in the course of investigations conducted across various modules of the Commission's Phase One inquiries.
- 7.3 With regard to the completion of this Volume, the following persons, who were identified as being of particular relevance to the question of Grace's care, were deceased by the date of establishment of the Commission, namely Ms Kitty Greaney, Children's Officer with the SEHB; Mr. X; Nurse N, Nurse Educator in Day Service Provider A; and Mr. H, the main bus driver who drove the bus upon which Grace travelled to and from Day Service Provider A. However, the Commission had certain documentary evidence related to the above individuals, which is reported upon, where relevant, in the chapters of this Volume.
- 7.4 Grace's mother, who resided outside the jurisdiction of the State, did not give evidence to the Commission. Through her solicitors, at the commencement of the Commission's work, she provided it with copies of the documentation in Grace's case that she had received from the HSE in 2010 pursuant to a freedom of information request which she had made.

- 7.5 As will be evident from the chapters in this Volume, a large number of persons who the Commission considered might be able to provide useful information about Grace's care were contacted by it and gave evidence to it which was relevant to the subject matter of this Volume. The Commission appreciates that these witnesses were giving evidence of events that had occurred, in some instances, over 20 years ago. In considering this evidence, the Commission was mindful at all stages of particular challenges faced by witnesses with regard to their memories of events and of their knowledge and awareness of issues over the timeframe under investigation. These were concerns almost inevitably to be encountered in an investigation commencing in 2017 into matters occurring during the period of time under consideration in this Volume. Many witnesses giving evidence had long retired, while some had moved to other employment.
- 7.6 The Commission has, where relevant, had regard to issues of age, frailty, ill health and other life circumstances impacting upon the giving of evidence and the clarity of witnesses' recollections. The Commission's considerations on matters relating to the memory of witnesses are set out in Chapter 1 of the First Substantive Interim Report.
- 7.7 Substantial documentation and records were provided to witnesses setting out the substance of evidence gathered by the Commission before they gave evidence. Many witnesses gave evidence that their memories were refreshed by the contents of the documentation and records provided. Other witnesses did not have recollections of particular events, independent of reference to such documentation and records. Some witnesses involved in Grace's care were seeing portions of the records regarding their involvement in Grace's case for the first time. The manner in which hearings were conducted is reported in Chapter 2 of the First Substantive Interim Report.
- 7.8 In seeking to establish the facts with respect to Grace's care, in particular with regard to the question of whether she suffered abuse, it is important to highlight that the evidence available to the Commission could never account for all the days of Grace's life with Family X. The evidence received by the Commission spanned a period of 20 years and was gathered from witnesses who encountered Grace at different times and in different circumstances. Some of those witnesses encountered Grace briefly at a particular point in time, while others encountered her more regularly or, in the case of household members, sometimes daily. Some witnesses had some involvement in Grace's care, while others did not. Many witnesses had first been

asked about their memories and impressions of Grace in her placement many years after they had met her.

- 7.9 There was an inevitable element of subjectivity inherent in the evidence, leading to apparent conflicts in it, particularly with respect to Grace's appearance and her presentation. Witnesses gave evidence from different perspectives, and without a uniform view with respect to standards of presentation and care. Inevitably, witnesses at the Commission were often giving evidence based on their impressions of Grace's level of care and her presentation in hindsight. There was often no contemporaneous note or record available to the Commission to provide assistance.
- 7.10 This was to be expected having regard to the nature of this inquiry into the care of a person over a period of 20 years from February, 1989 to July, 2009. These matters were taken into account when assessing the strength, weight and reliability of the evidence in establishing the relevant facts, on the balance of probabilities, and making findings with respect to Grace's care and the question of whether she had been subjected to abuse.
- 7.11 The Commission is satisfied that it was in a position to establish the facts of the matters reported upon in this Volume in accordance with its Terms of Reference, taking all of the above considerations into account.

8. Mrs. X

- 8.1 As set out in the Commission's First Substantive Interim Report,² Mrs. X was not legally represented before the Commission. She had made efforts to obtain representation and, in the early stages of its investigations, the Commission had communicated with her for the purpose of assisting her in that regard. Mrs. X proceeded to engage with and give evidence to the Commission without any legal assistance or representation. As with all parties who came to give evidence to the Commission in such circumstances, the Commission was vigilant at all times to ensure that fair procedures were accorded to Mrs. X for the taking of her evidence, which evidence was required across every part of the Commission's investigations under the Terms of Reference, spanning over 20 years.

² See paragraphs 15.2 to 15.6 of Chapter 1 of the First Substantive Interim Report.

- 8.2 Having regard to Mrs. X's age, her general state of health, the arrangements necessary for the taking of her evidence on a periodic basis, and the fact that she was not legally represented, the Commission examined Mrs. X on her evidence in a series of individual hearings over time with the Commissioner and the Commission's legal representatives. The Commission thereafter provided transcripts or transcript extracts of Mrs. X's evidence to certain parties, where appropriate to the Commission's inquiries. Grace's Committee in Wardship and the representatives of the HSE were given an opportunity to apply to the Commission to cross-examine Mrs. X on the transcripts of her evidence. The legal representatives of both Grace's Committee in Wardship and the HSE duly cross-examined Mrs. X on aspects of her evidence at a separate hearing of the Commission.
- 8.3 In evaluating the weight to be attached to the evidence of Mrs. X, as with other witnesses who gave evidence, the Commission considered the reliability and credibility of that evidence, taking into account all other evidence provided to it concerning Grace's care and the weight to be attached to such evidence. The Commission took account of the fact that Mrs. X's recall of certain matters was sometimes confused and contradictory and that her memories were somewhat fragmented and, at times, conflated with other events or timeframes. Wherever such issues arose, in order to assess the probative quality or persuasiveness of Mrs. X's evidence and to determine the matters at issue, the Commission carefully considered and weighed all of the available evidence, including any corroborating or contradictory evidence from other witnesses or contained in the documentation before the Commission. As with all witnesses, the Commission distinguished between those aspects of Mrs. X's evidence which were credible or reliable and those which were not and determined their significance. Where the Commission found the evidence to be unreliable or not credible, it has stated this in its reports. The facts established by the Commission, as reported in this Volume, reflect the extent to which evidence, including that of Mrs. X, was accepted or rejected on certain matters.

9. Apologies of the HSE

- 9.1 Prior to the establishment of the Commission, the HSE made two apologies with respect to Grace's case. A third apology was made shortly after the Commission's establishment. These apologies were contained within three letters, namely a letter dated 25th January, 2016 addressed to Grace, a letter dated 27th January, 2016

addressed to Grace's mother, and a letter dated 24th April, 2017 addressed to Grace in the course of the settlement of High Court proceedings issued on Grace's behalf.

- 9.2 These matters have already been reported in the First Substantive Interim Report and Appendix 1 thereto.

Apology of 25th January, 2016

- 9.3 The HSE's apology of 25th January, 2016 to Grace was in the following terms:

"I am writing to apologise to you for the failings in your care while placed with a foster family for 20 years up to 2009.

There is no doubt that you experienced a number of very serious failings in your care during this time. These included:

- *Inadequate monitoring and over sight of your care,*
- *An absence of necessary liaison between those responsible for your placement in the foster home,*
- *Inadequate or timely action to remove you from your foster home after significant concerns had been raised,*
- *An absence of the necessary protocols and arrangements to support the placement of vulnerable children & adults with a disability in foster families.*

When taken together there is no doubt that the care that you received fell far short of the compassionate, caring and personalised support that you were entitled to. Moreover you experienced a level of neglect and abuse that should never have happened as swifter action should have been taken to protect you and ensure your needs were being addressed appropriately. For all of these failings, as Chief Officer of the South East, I wish on behalf of the HSE, to sincerely apologise to you."

Apology of 27th January, 2016

9.4 On 27th January, 2016, the HSE wrote to Grace's mother to *"apologise to you for the failings in the care provided to your daughter [Grace] while placed with a foster family for 20 years up to 2009".*

9.5 The letter stated that there was *"no doubt"* that Grace had experienced *"a number of very serious failings in her care during this time. These included:*

- *Inadequate monitoring and over sight of [Grace's] care,*
- *An absence of necessary liaison between those responsible for [Grace's] placement in the foster home,*
- *Inadequate or timely action to remove [Grace] from the foster home after significant concerns had been raised,*
- *An absence of the necessary protocols and arrangements to support the placement of vulnerable children & adults with a disability in foster families."*

9.6 The letter went on to say that there was *"no doubt that the care that [Grace] received fell far short of the compassionate, caring and personalised support that she was entitled to. Moreover [Grace] experienced a level of neglect and abuse that should never have happened as swifter action should have been taken to protect her and ensure her needs were being addressed appropriately. For all of these failings, as Chief Officer of the South East, I wish on behalf of the HSE, to sincerely apologise to you."*

Apology of 24th April, 2017

9.7 The HSE wrote a similar letter to Grace on 24th April, 2017. This was sent to Grace in the course of proceedings taken on her behalf against the HSE (and after the publication of the *Devine Report* and the *Resilience Report*).

9.8 In this letter, the HSE apologised *"unreservedly"* to Grace *"for the failings in your care while placed with a foster family for 20 years up to 2009."* Particulars of the *"very*

serious failings” were set out and were the same as those listed in bullet point form in the aforementioned letter to Grace’s mother. Again, it said that the care she received *“fell far short of the compassionate, caring and personalised support that you were entitled to”*.

Commission’s questionnaires to HSE and HSE’s responses

- 9.9 On 29th August, 2017 the Commission sent a questionnaire to the HSE requesting its assistance in providing it with an account of the precise factual basis upon which each element of the apology made to Grace by letter of 24th April, 2017 was based.
- 9.10 On 12th September, 2017 the Commission sent a further questionnaire to the HSE requesting its assistance in providing it with an account of the precise factual basis upon which the HSE apologised for the *“neglect and abuse”* of Grace in the apology given by letter to Grace’s mother on 27th January, 2016.
- 9.11 A final clarification of certain matters contained in the answers to the second questionnaire was sought by letter of 20th March, 2018.
- 9.12 As can be seen from that correspondence, which is set out at Appendix 1 to the First Substantive Interim Report, in the questionnaire enclosed with the Commission’s letter of 12th September 2017, the Commission had queried with the HSE the precise nature of the abuse (as defined in its Terms of Reference) for which that apology was made.
- 9.13 In response, the HSE listed a number of instances of reported injuries to Grace from the *Devine Report*,³ which the HSE said gave cause for concern.
- 9.14 In its letter of 20th March, 2018, the Commission asked the HSE if it had concluded that the instances in question arose as a result of actual physical abuse perpetrated upon Grace.
- 9.15 The HSE replied in the negative by letter of 6th June, 2018, stating that the apology issued *“following a review of the totality of the Devine and Resilience Reports and in circumstances when extracts of those [Reports] were to be published. Those Reports*

³ Report of Conal Devine & Associates Inquiry into Protected Disclosures, SU1 (2012).

identified failings on behalf of the HSE/SEHB and the apology was issued in that context and written corporately on behalf of the HSE.”⁴

10. Phase Two considerations

- 10.1 On the establishment of the Commission, the Government provided for investigations to be conducted in two separate phases. Phase One was directed and limited to investigations in Grace’s case and to establishing *“the facts regarding the role of public authorities in the care and protection of a service user, Grace (pseudonym), who resided with a former foster family (Family X) in the South East of Ireland between 1989 and 2009”* as set out in Parts III to IX of the Terms of Reference governing the Commission’s investigations.
- 10.2 For the purposes of carrying out its Phase One investigations and establishing the facts in respect of Grace’s care, as reported in this Volume, the Commission conducted wide inquiries and took extensive evidence from persons who could assist it.
- 10.3 Following completion of Phase One, pursuant to Part X of the Terms of Reference, the Commission, having regard to the facts established through its investigations into Grace’s case pursuant to Parts III to IX of the Terms of Reference, and information in its possession, is to consider the question of further investigations (if any) *“having regard to the facts established and information in its possession including the report by Conor Dignam SC in his Review of Certain Matters Relating to a Disability Service in the South East (29th August 2016) and his recommendations regarding the areas to be examined by a Commission of Investigation contained in Chapter 4 of that report.”*
- 10.4 Part X sets out that, for the avoidance of doubt, that includes having regard to the recommendations concerning *“Care and Decision Making in respect of Others, Actions of the HSE in terms of investigating/protecting others”* together with other matters contained in the *Dignam Report*. The Commission is presently engaged in considering Part X.

⁴ Report of Resilience Ireland Ltd. Disability Foster Care Report HSE South East (2015).

- 10.5 With respect to “*Care and Decision Making in respect of Others*” and “*Actions of the HSE in terms of investigating/protecting others*” the Commission will have regard to the information in its possession relating to allegations which have been made by or on behalf of some other persons (sometimes referred to as service users) who stayed in Family X’s household, against Mr. and/or Mrs. X, whether in the course of the Garda investigations into the placement or otherwise (even though no criminal prosecutions resulted from those investigations).
- 10.6 With respect to the above, out of 47 persons who, from the information in the possession of the Commission, had spent time in the Family X placement, there are some persons by or on behalf of whom allegations of “abuse” (as defined under the Terms of Reference) have been made against Mr. X and/or Mrs. X and which include allegations against them of serious and concerning matters. It should also be stated that there were no allegations or complaints made by or on behalf of a substantial proportion of the above 47 persons.
- 10.7 It is not appropriate for the Commission to set out any detail in this Volume with respect to these allegations that are uninvestigated by it, where they do not form part of the Commission’s inquiries mandated pursuant to the Terms of Reference set for Phase One.
- 10.8 The exception to this position insofar as the Commission’s Phase One investigations were concerned was primarily necessitated by Term of Reference IV d), which required the Commission to establish the facts relating to the treatment and investigation by the SEHB, any other Health Board or the HSE of any allegations made in respect of Family X and communicated to any Health Board or the HSE by any party whatsoever, as referred to in the *Devine Report*. This Term of Reference required the Commission to investigate the way in which the allegations that were made on behalf of E.E. in 1996 and Z.Z. in 1992 were treated and investigated by the SEHB. Those investigations were limited to the requirements of the Term of Reference and to the impact, if any, of the SEHB’s treatment and/or investigation of those allegations on the management of Grace’s case, bearing in mind that the Phase One investigations were specifically limited to Grace’s case.
- 10.9 In the above regard, the Commission’s First Substantive Interim Report has reported upon the nature of the allegations made of behalf of E.E. in 1996 and communicated

to the SEHB and the manner in which they were addressed in the context of Grace's case at that time.

- 10.10 Volume 5 reports upon the nature of the allegations made on behalf of Z.Z. in 1992 and the manner in which these were investigated by the SEHB at the time.⁵

11. Methodology

- 11.1 The methodology adopted by the Commission in the investigations underlying this Volume remains as described in Chapter 2 (Methodology) of the Commission's First Substantive Interim Report.
- 11.2 The work of a Commission is inquisitorial in nature. The role of this Commission was to inquire into the matters of significant public concern referred for investigation and to do so independently, from a neutral standpoint, and with an open mind. To this end, it was for the Commission to identify, seek out, question and consider carefully all of the witness testimony, records and documentation disclosed in the course of its work that could assist in arriving at the truth of each matter under investigation.

⁵ Chapter 4 of this Volume also refers to the allegations in relation to E.E. and those in relation to Z.Z. under the heading "*Previous allegations*" in Section 1. Communication between Mrs. Z and the HSE is also reported in Chapters 1 and 2 of Volume 1.

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CHAPTER 2

1. The question of physical abuse

Introduction

- 1.1 The purpose of this Chapter is to consider and report upon the evidence provided to the Commission in Phase One of its investigations on the question as to whether there was evidence that Grace was physically abused while living with Family X.
- 1.2 The question as to whether Grace suffered abuse of a physical nature when living with Family X was a central issue to be investigated under the terms of reference set for the Commission. As with all other aspects of potential areas of abuse, in focusing on evidence gathered by it relevant to this question, the Commission also had regard to the facts established in other aspects of Grace's care and to relevant contextual evidence on her life, which is referred to throughout this Volume.

Issues of concern

- 1.3 Grace's physical presentation and the observation of marks, bruising and scratches on her from time to time attracted differing levels of attention, concern and comment and were viewed as having arisen for differing reasons over the time reported upon in this Chapter.
- 1.4 It is important to note that, taken in isolation and without explanation, the presence of bruising, marks or scratches on a child or woman with Grace's vulnerabilities and disabilities (the details of which are reported upon below) would clearly be a matter of considerable concern. It bears emphasis that Grace cannot assist the Commission with her own account of how these occurred.
- 1.5 A centrally important issue to be investigated by the Commission, reported upon in this Chapter, is as to whether these marks or injuries were accidental injuries, or whether they occurred as a result of Grace's having been subjected to physical abuse. In this regard, however, the Commission cannot proceed on the basis that the presence of marks or minor injuries to Grace, of themselves, *prima facie* established that Grace was subjected to abuse.

No direct evidence of physical abuse of Grace

- 1.6 There was no direct evidence provided to the Commission of Grace's having been subjected to physical abuse by Mrs. X or Mr. X or by anyone in the Family X household, or by any other person in any other location, throughout the period under investigation by it in accordance with term of reference V. a) and term of reference VIII. a).
- 1.7 In the course of the Commission's investigations into the issue, Mrs. X and the members of the Family X household refuted and denied any suggestion that Grace had been subjected to physical abuse.
- 1.8 The Commission's First Substantive Interim Report refers to apologies which the HSE made to Grace and her mother in January, 2016 relating to failings by the SEHB/HSE in Grace's care, both of which referred to Grace's having suffered "*abuse*" during her time with Family X.¹ This is a matter that is referred to also in the Introductory Chapter to this Volume. It is recommended that both the First Substantive Interim Report and the Introductory Chapter to this Volume be read in conjunction with this Chapter.

2. Context

- 2.1 The investigation of events concerning the question as to whether Grace suffered physical abuse, and, if so, where and when and by whom, could not be undertaken without taking into account the reality of her life and certain contextual matters relevant to her behaviours, presentation and challenges. These derive from the extensive evidence that emerged throughout the course of the Commission's investigations. These are areas of relevance to an understanding of Grace's life circumstances when viewing the concerns that arose as to whether she was subjected to physical abuse.
- 2.2 The contextual matters to be outlined fall within the following headings:
- self-injurious behaviours;
 - Grace's physicality and hyperactivity;

¹ Appendix 1 to the First Substantive Interim Report contains correspondence between the Commission and the HSE in relation to this matter.

- Grace's experience of the bus; and
- Grace's incontinence.

3. Self-injurious behaviours

Preliminary

- 3.1 Grace was observed to be hyperactive from early childhood and before the time that she was placed in foster care with Mrs. X in February, 1989. Observations to this effect were documented as early as the age of three in a letter from the Children's Officer of the South Eastern Health Board following consultation with Dr. Vincent Moloney in the Eastern Health Board ("EHB") and in two reports from different psychologists when Grace was six years old.
- 3.2 In an EHB psychologist's report on Grace dated 13th February, 1985 (conducted when she was six years old), the psychologist described her as "troublesome". The report went on to describe how Grace's concentration "*deteriorated sharply*" approximately 10 minutes into being seen by the psychologist. The report continued: "*She screamed frequently in a piercing fashion and would sometimes quit on request, others not...She sometimes responds to simple commands but frequently ignores these.*"
- 3.3 In a psychiatric assessment from Saint Patrick's School, Kilkenny, dated 9th April, 1985, a consultant psychiatrist recorded that: "*The major problem that [Grace] presents is her over activity which requires constant attention and she has a tendency to climb/ investigate and amuses herself by making noise*".
- 3.4 In a further psychologist's report dated 12th September, 1986, conducted when Grace was seven years old, the psychologist noted that Grace was "*extremely active generally*" and that her "*hyperactivity was very evident during the assessment as she continually tried to run around the room. Her concentration deteriorated sharply after about five minutes. She indicated she did not want to co-operate by screeching in a piercing fashion and trying to push toys away...She sometimes responds to simple instructions...but frequently ignores them.*" The psychologist noted that Grace was not toilet trained.

- 3.5 In a psychologist's report, for which Grace was assessed in January and February, 1989 (at nine years of age), an EHB psychologist described her as being "*extremely hyperactive*" and as "*very hyperactive, continually climbed furniture and seemed unaware of the danger of falling. Her hyperactivity makes it difficult for her to concentrate for many short tasks...*" The psychologist noted that Grace was not toilet trained. In the section of the report entitled "*Adaptive Behaviour Scale*", the psychologist noted: "*She hugs others inappropriately [and] does not let go, and also head butts...She occasionally bangs her head against the floor.*" This was immediately before Grace's placement into foster care with Mrs. X.
- 3.6 In a psychologist's report in 1989, for which Grace was assessed on 3rd August, 1989, Mr. Enda McGovern, Clinical Psychologist with the Brothers of Charity, noted that she showed "*some enjoyment at the sound she hears, hitting objects off surfaces and also hitting them off herself*".
- 3.7 Grace was known to have certain behavioural patterns, which included banging her head and head-butting and, on occasion, "*smacking*" herself. In describing these behaviours, the Commission adopts the terminology of "*head-banging*" and "*head-butting*", as these terms were generally used throughout the records and documentation disclosed to it, including assessments of Grace and the minutes of meetings prepared by health board personnel, and by Mrs. X.
- 3.8 Grace also had a tendency to scratch her skin.
- 3.9 The issues of Grace's head-banging and her habit of scratching her skin are considered below, as components of the self-injurious behaviours in which she engaged.
- 3.10 These behavioural patterns were well established by the time Grace was placed in foster care with Mrs. X in February, 1989. Such self-injurious behaviours were also recorded by Grace's former foster father in June, 1984, as well as in the report dated January, 1989 from the Sister-in-Charge of the school Grace was attending the month before she was placed with Mrs. X, the details of which are referred to at paragraph 3.14 below.
- 3.11 These self-injurious behaviours continued to be observed after Grace was placed into foster care with Mrs. X, in the period from February, 1989 onwards. The

Commission is satisfied that they were observed by Mrs. X at home, by the manager and staff at Day Service Provider A, which Grace started to attend from 1995 onwards, and on the bus to and from Day Service Provider A. The frequency and intensity of these behaviours varied significantly.

- 3.12 These types of behaviours continued after Grace was removed from her home with Mrs. X. The serious exacerbation of these behaviours, which were of a different character after July, 2009, is reported in Chapter 4 of this Volume (the circumstances surrounding the decision by the HSE to move Grace from her home with Mrs. X into a residential placement on 17th July, 2009, as well as the decision to expedite the move, and the manner in which this move was effected is addressed in Part 2 of Volume 1, particularly Chapter 20).

Head-banging

Evidence in respect of period prior to 1989

- 3.13 Grace's early years, including the details of reports and assessments with respect to her during that period, have already been reported in detail in the First Substantive Interim Report, which should be read with this Volume.
- 3.14 In the report of 27th January, 1989, which was written by the Sister-in-Charge at Grace's school one month prior to her moving in with Family X, her "*General Behaviour*" was described as follows:

"Hyperactive. Short concentration span. 'Head bangs' now as she hugs the other children. The bouts of screaming and hysterical laughter have stopped. We sometimes have the odd crying outburst. Has started to become interested in pretend play. Pincer grasp still not fully established. Still a loner. Is noticeably quieter since she has gone to crisis care – we feel she misses her mum."

- 3.15 Dr. Elizabeth Morrissey Walsh, Acting Senior Area Medical Officer, SEHB, told the Commission that Grace had a history of what a psychologist in the EHB area called "*maladaptive behaviour*". Dr. Walsh described how Grace "*reacted poorly*", "*head-banging and so on*", to a change in environment. When giving evidence to the Commission, Dr. Walsh questioned whether Grace's behaviour after she first started to attend Day Service Provider A in 1995 was a manifestation of her adapting poorly

to change and becoming upset, which, Dr. Walsh opined, could happen in the initial change period. It caused a concern for her, she said, in the context of any future move of Grace to a residential placement.

Mrs. X's evidence

- 3.16 Mrs. X told the Commission that Grace *"was always head-banging"*. Mrs. X also gave evidence that she regularly banged her head on the bus to and from Day Service Provider A, and particularly off the window of the bus. Mrs. X said that she was told this by the bus driver. When asked about whether this would happen on a daily basis, Mrs. X said that Grace banged her head *"all of the time"* and *"everywhere"* and that this also sometimes happened at home.
- 3.17 Mrs. X's evidence as to the frequency of Grace's behaviour of head-banging or her assertion that this occurred *"all of the time"* was not consistent with her other evidence as to how Grace was at home (that she was *"no trouble"*) or with the evidence of other household members. The Commission is satisfied that this description of frequency was an overstatement or exaggeration by Mrs. X of Grace's behaviour at this point in her evidence. The Commission is not satisfied that this was a constant activity on Grace's part, but rather behaviour that she would engage in if she got excited, or if something was bothering her, or if she was annoyed or unhappy, or if someone took her keys. In this regard, Mrs. X described how Grace would go to the wall and bang her head against it, or hit her head off the table. The substance of Mrs. X's evidence, taken with that provided by Day Service Provider A personnel, tended to suggest that Grace's head-banging varied from time to time, in terms of its intensity and force, between banging, at one extreme, and tapping, at the other.
- 3.18 According to Mrs. X, Grace was always banging herself with the plastic keys that she carried with her. This was also witnessed by Gamma (Mrs. X's nephew) and Alpha (her grandson), and at Day Service Provider A, where it was variously described as banging or tapping.
- 3.19 Mrs. X recounted how Grace would engage in head-banging when they were out socialising and how, if there was a crowd of people, it would get worse, recalling that they had to leave restaurants several times on account of her behaviour. Gamma

and Alpha's evidence was that Grace's behaviour was okay in restaurants, but they also related how Mrs. X would control her by telling her to stop.

- 3.20 On speaking with Mrs. X in June, 1997 for the purpose of completing a standardised form with information about Grace for use in Day Service Provider A, Mr. M noted with respect to "head-banging" that Grace *"hasn't done this for a long time. Only happened when she first attended [Day Service Provider A]"*. Mrs. X could not remember this conversation, but said that this was correct and that *"[t]hat is because she was unhappy at the start"*. Mrs. X told the Commission that Mr. M's note to the effect that she was *"worried about [Grace's] coming to [Day Service Provider A] at first now happy"* was accurate, adding that *"[Grace] always did [bang her head], but she hadn't done that for some time."*
- 3.21 Mrs. X recalled that Grace would also try to head-butt other people. Head-butting was also reported to Mr. M by the driver of Grace's bus to and from Day Service Provider A, referred to further below.
- 3.22 Mrs. X told the Commission that, as a result of head-banging or head-butting, Grace would have slight marks on both sides of her forehead and sometimes in the middle of it. When asked if the head-butting activity ever drew blood or caused bruising, Mrs. X said that it did not. She said that she remembered bleeding only once (indicating above the left eye), when Grace had been on the bus.

Evidence of Day Service Provider A personnel

- 3.23 The Commission also heard evidence from the staff of Day Service Provider A about Grace's head-banging.
- 3.24 CW6 and CW7, both programme assistants at Day Service Provider A, recalled Grace's banging her head from time to time.² Both gave evidence that she banged the side of her head against walls, and CW7 said that she would also sometimes bang her head against the bus window. CW8, programme assistant at Day Service

² CW6 started a 12 week placement in Day Service Provider A from March until May, 2004. In June, 2006 she began part-time work there. In November, 2007, she became a full-time care assistant at Day Service Provider A. CW7 started working there in February, 2008.

Provider A, also recorded Grace engaging in head-banging (referred to in the incidents considered below).³

- 3.25 CW4 was a programme assistant at Day Service Provider A.⁴ She had made a note in September, 2009 when Grace lay down on a footpath and began to knock her head on the ground. She told the Commission that, other than being concerned for Grace's safety, the fact that she was knocking her head off the ground was not something that would have caused "*huge concern*" for her. This, she said, was because so many of the service users had different behaviours and different "*traits*". CW4 said that she "*vaguely*" remembered Grace's banging her head but that she could not recall specific incidents.
- 3.26 CW2, who was also a programme assistant at Day Service Provider A at that time, told the Commission that Grace banged her head sometimes but "*not often*."⁵ She said that the staff tried to distract Grace or to stop her from doing it and that they were generally successful in doing so. CW2 said that she was aware at the time that there was a problem with her banging her head on the bus as well.⁶
- 3.27 Referring to regression when Grace came back to Day Service Provider A after an absence and the need to walk her through her routines again, Mr. M, who was the manager at Day Service Provider A from the time of its establishment to 2008, told the Commission that head-banging, hitting her head, or screaming were behaviours that Grace could display. Mr. M's report on Grace dated April, 1996, is reported in the Commission's First and Second Substantive Interim Reports.
- 3.28 Mr. M told the Commission that, in his experience, someone who engaged in head-banging could revert to it at any time, describing how it was not a behaviour that one could "*cure*" because of how it could recur "*on a bad day or [at] a bad moment*". Mr. M said that to say that Grace had only engaged in head-butting when she first attended at Day Service Provider A was partly true, noting that she did it again "*many times afterwards*", particularly when she was bored or frustrated, or on the bus.

³ CW8 started work in Day Service Provider A and worked there until April, 1998. She returned for a brief period of around two months in 2008 and also provided some relief work. She later moved to the local voluntary association's residential service (and continued to do so at the time she gave evidence to the Commission. In total, she worked in Day Service Provider A for around 21 months during the time when Grace lived with Family X.

⁴ CW4 did a year long placement at Day Service Provider A, finishing around August or September, 1997. She returned to work there in 1999 for a three month placement through her college course and remained after that placement ended as Nurse N was on sick leave. CW4 continued working at Day Service Provider A until just before she commenced a new job in June, 2000.

⁵ CW2 worked in Day Service Provider A from 1997 to 2009, when Grace was moved from Mrs. X's, and beyond.

⁶ CW2's recollection was that she was Grace's assigned Key Worker in 2007.

- 3.29 On 12th January, 2009, a General Risk Assessment Form in relation to Grace, which was completed by Ms D (who commenced working at Day Service Provider A as Day Service Manager on 31st March, 2008), noted: *“Nature of risk identified Banging her head when distressed or elated”*. This was described as presenting a *“medium”* risk.
- 3.30 Regarding this risk of head-butting, Ms D noted as follows:
- “Method used to reduce or manage the risk: Staff to provide a structured programme and distract [Grace] if she engages in banging her head. A foam cushion is to be used by staff”*.
- 3.31 Ms D told the Commission that, in late 2008/ early 2009, a new system of general risk assessment was introduced at Day Service Provider A, whereby the areas that needed supports in order to reduce risks that service users might face were identified. Ms D said that Day Service Provider A’s reports and recorded observations showed that Grace sometimes banged her head and that there existed a risk, which was *“medium”* in nature, that she could harm her head.
- 3.32 Ms D gave evidence that the head-butting behaviour that Grace engaged in at this time was *“distinctly different”* from the severe head-butting that she exhibited after she moved into the residential unit in July, 2009 and became *“unwell.”* Ms D said that whereas Grace’s behaviour prior to the move involved *“very light”* head-butting, following the move, she *“couldn’t stop herself”*. The impact of the move to residential care upon Grace is reported in detail in Chapter 4 of this Volume.
- 3.33 These episodes, described by the above witnesses before the Commission, involved Grace’s banging her head off the wall, the floor, on the bus to and from Day Service Provider A, and particularly against the bus windows. On occasion, Grace also ran at others with her head or *“head-butted”* others. This caused a concern for the staff of Day Service Provider A, as Grace was unknowingly hurting others in the day centre and on the bus when she did so.
- 3.34 The instances of head-butting and head-banging occurred from an early age and the Commission is satisfied that they were considered to be occasioned by and associated with Grace’s general condition and level of intellectual disability.

3.35 As reported upon in Section 5 below, Grace also had sensory processing difficulties which manifested themselves in certain behaviours. These behaviours could be associated with specific circumstances, but could also occur for no specific or identifiable reason. They happened when she was bored, but also when she was excited or frustrated, annoyed or upset. They could happen when her plastic keys were taken from her, although sometimes the keys were taken from her with the aim of calming her. The Commission is satisfied that these behaviours could also occur if Grace was not feeling well or when she was in pain.

3.36 The evidence to the Commission established that these were not considered to be surprising behaviours, and were of a type of behaviour associated with Grace's level of intellectual disability. These behaviours were a concern with respect to her own safety and because of the risk of her hurting herself, but not a concern in themselves. Rather, they constituted a particular trait or characteristic of Grace's. Efforts were made to stop or distract her with varied success.

3.37 Commenting upon self-injurious behaviour generally, Mr. McGovern, who assessed Grace on a number of occasions, told the Commission that:

"It's certainly very much part and parcel of the repertoire of abnormal behaviour that someone with a severe or profound intellectual disability presents with. It's persistent, it is often longstanding and intractable..."

3.38 It was evident from the accounts about Grace's day-to-day life at home and in Day Service Provider A that this behaviour did not occur every day and was not a constant activity throughout the day. These accounts of her day-to-day life are reported in Chapters 3 and 6 of this Volume.

3.39 Grace's behaviour of head-butting was not a new behaviour when she started attending Day Service Provider A in 1995. However, there was evidence that it became a particular difficulty for her when she was travelling unaccompanied to and from Day Service Provider A on the bus. The difficulties for Grace on the bus to and from Day Service Provider A are reported further below under the heading "*Grace's experience of the bus*".

- 3.40 The Commission is satisfied that, in all likelihood, the above behaviour resulted in Grace's sustaining marks or injuries to herself from time to time, depending on the intensity of it and the extent to which the behaviour was prolonged on any occasion. Having regard to the evidence before the Commission, it cannot rule out that these behaviours caused her to suffer minor injury at times to the areas of her head, face and eyes.

Scratching of skin

- 3.41 Grace suffered from acne vulgaris, a skin condition that caused her irritation. As a result of this, she was prone to scratch herself. There were reports of her sometimes scratching herself with the plastic keys that she carried with her at all times. The Commission heard evidence of Grace's scratching herself regularly at home, on the Day Service Provider A bus, and also during the day at Day Service Provider A.
- 3.42 Grace continued to suffer from this skin condition and to scratch her skin in the period following her move from the home of Mrs. X in July, 2009.

Mrs. X's evidence

- 3.43 Mrs. X told the Commission that Grace suffered from acne and that she used to "bang" and scratch herself using the plastic keys that she carried, including when she slept at night-time. According to Mrs. X, Grace tended to scratch her face, teeth, gums, ears, back, and chest. Mrs. X said that she used to cut Grace's fingernails in order to prevent her from scratching her skin.
- 3.44 Mrs. X initially said that Grace's scratching did not lessen with the passage of time. However, she subsequently indicated that, although her scratching had eased somewhat by the time she turned 20 years of age, it was still something that she engaged in after that time. Mrs. X did not know the reason for Grace's scratching and told the Commission that all she could do in order to try to stop her from doing it, was to try to occupy her mind. Mrs. X recalled how, on occasion, she would do this by giving Grace water and sand in an attempt to distract her. She said that she would also tell her to stop scratching but that this had no effect. When Grace scratched herself in bed at night, Mrs. X said that there was nothing that she could do to stop her.

- 3.45 Mrs. X recalled how Grace could begin to scratch herself without any discernible reason or trigger.
- 3.46 In addition to scratching herself, Mrs. X told the Commission about Grace's tendency to bang her teeth and her ears with the plastic keys that she carried, adding that this would sometimes result in bleeding from her gums or from her ears. Mrs. X also said that Grace sometimes had blood in her nose and eye areas, which she said was as a result of her scratching herself with the plastic keys, and which she said "*often happened*".
- 3.47 Mrs. X told the Commission that she sometimes took the keys from Grace but that this did not stop her from scratching herself, adding that she would sleep through the night as long as she had her plastic keys. Mrs. X also said Grace was always chewing on the keys. She remembered bringing Grace to the doctor once and said that the doctor told her to take the keys off her, but Mrs. X said during her evidence that she could not do that; that she had been told not to do that. The issue of how Grace's plastic keys were managed is reported upon in Chapter 6 of this Volume.

Evidence of other household members

- 3.48 In giving evidence to the Commission, Alpha said that Grace tended to scratch herself with the plastic keys and that this scratching and "*tipping*" of the keys against her teeth had, at times, caused her gums to bleed. Similar to Mrs. X, Alpha recalled how Grace would sometimes start to tap her teeth with the plastic keys for no apparent reason or trigger.
- 3.49 Gamma recalled seeing Grace with the keys and her "*prodding*" her gums with them. He also remembered seeing her "*stick [the keys] in her teeth*", describing her as "*tipping away*". He said that this caused her gums to bleed. Gamma said that he did not see Grace scratch any other part of her body with the keys and that he did not see any scratches on her that were in any way "*out of the ordinary*".
- 3.50 Beta, who lived on the property owned by Family X, did not remember seeing scratches on Grace. Nor did he recall ever seeing her scratch herself with the keys or put them to her mouth.

Evidence of Day Service Provider A staff

- 3.51 Mr. M also gave evidence of having been aware of Grace's scratching herself and of her suffering from particularly noticeable acne, commenting during his evidence that "*poor [Grace]...was forever scratching it*". He said that the staff at Day Service Provider A were always trying to distract her from scratching herself. Mr. M said that usually, when Grace was out on the bus during trips organised by Day Service Provider A, a staff member would sit beside her or in the seat behind her, so as to prevent her from scratching her skin.
- 3.52 Mr. M did not recall ever seeing Grace use her plastic keys to scratch herself, but added that this was not to say that it did not happen.
- 3.53 When giving evidence, CW2 agreed that Grace had a tendency to scratch herself, although she could not recall Grace suffering from acne. CW2 said that when Grace was not "*in the best of form*", she would scratch at her face, her arms, her back, or sometimes her leg. She recalled how sometimes there would be "*a little bit of blood*" as a result but that, mostly, the scratching resulted in scratch marks alone. CW2 said that Grace sometimes came to Day Service Provider A with scratches in an unhappy state. Other times, however, she said that Grace would arrive there with scratches but in "*okay form*". CW2 recalled how Grace would often remove her clothes on arriving at Day Service Provider A in order to take a bath and that scratches would be evident on her body. She told the Commission that her view at the time was that the scratches that she had seen on Grace over the years that she cared for her were self-inflicted.
- 3.54 CW4 recalled Grace as having acne and seeing blood under her fingernails but she did not recall her scratching at her face.
- 3.55 CW1, who was initially employed in 1997 as a care assistant at Day Service Provider A and then went on to work there as a programme assistant and as a programme supervisor before finishing work there in 2000, recalled that Grace suffered from acne but she did not remember her scratching it using her plastic keys or otherwise. Her recollection was that she only held the keys "*up near her eyes*."
- 3.56 CW7 also recalled that Grace had acne, describing her as having "*quite bad skin*". She recalled that she scratched her skin as a result.

- 3.57 With respect to the present day, Ms D said that, as at the time that she gave evidence to the Commission, Grace “*scratch[ed] her skin*” as “*sometimes she has dry skin*”. She said that “[Grace] *presented with scratches sometimes and [Grace] still presents with scratches now*”. In relation to efforts to control this scratching, Ms D said that “*there would have been efforts made to keep [Grace’s] nails short and such and that’s ongoing*.” Separately, Ms D said that Grace had a tendency to scratch due to her having particularly oily skin.
- 3.58 The fact that these efforts were described by Ms D as ongoing, even at the date she gave evidence to the Commission, long after Grace was moved from Mrs. X’s care, speaks to the persistence of this skin problem.
- 3.59 The Commission is satisfied that Grace suffered from the common skin condition known as acne vulgaris from adolescence into adulthood. Bearing in mind that itchiness and irritation are commonly known features of acne, the Commission is satisfied on the evidence before it that Grace had a tendency to scratch her face and body. Marks were present on her face and body from time to time and were recorded in the notes prepared by Day Service Provider A personnel as a result of such scratching.

4. Grace’s physicality and hyperactivity

Preliminary

- 4.1 The Commission heard evidence that, from a young age, Grace could be very excitable and physical in her participation in certain play or leisure activities. Her love of physical activity and climbing and running was also identified as a feature of her hyperactivity at an early age.
- 4.2 Ms D said in her evidence that Grace found it difficult to maintain her concentration and that she had a “*very, very short*” concentration span. Ms D recalled how Grace spent a lot of time coming into the offices at Day Service Provider A or going from one room at the day centre to another, adding:

“[Grace] found it difficult to wait for different activities. She found it difficult if she wanted your attention, if that wasn’t given to her straight

away. So, she would hold on to you. She would link your arm, sometimes she might lean in on top of you...

- 4.3 CW2's description of Grace as somewhat "*unpredictable*" in her movements was borne out by similar descriptions of her given to the Commission.

Swings

- 4.4 In particular, the Commission heard evidence, from both Mrs. X and from the staff of Day Service Provider A, about how Grace loved to play on swings (there was a swing in the garden at the home of Family X which Grace used regularly) and slides. Mrs. X recalled how, on a nice day, Grace would be let out on the swing for about 20 minutes at a time.

- 4.5 The Commission heard how the staff of Day Service Provider A tried to ensure that two staff were present when Grace used the swings there and that Grace would not slow down on them, even when they asked her to. In particular, Mr. M recalled that:

"[Grace] would take your life when she got on the swings, absolutely loved it. But she could swing almost to the top of the thing and you would be stood there watching her thinking 'she is going to come off at the top of the thing'...But in getting on the swing she was rough kind of thing with the chains and everything like that".

- 4.6 Mrs. X described Grace as "*dead happy*", though "*very rough*" when she used the swings. Mrs. X recalled having to stand quite close to Grace when she was on the swing because of how excited she would get and how high she would go. She said that Grace also used to jump off the swings. She recalled Mr. M's expressing concern that Grace might "*tumble out*" of the swings but she said that that never actually happened.

- 4.7 Mrs. X told the Commission that, when she went to bath Grace, she would often notice marks on her from "*the swings and things*". Referring in particular to scratch marks that she observed in or around 1999, Mrs. X said that they were "*marks that would [happen] to anybody*". She said that the marks were on her legs and referred in particular to a mark on her right thigh at one time which, she said, was "*definitely [caused by] the swings.*"

Walking and use of tricycle

- 4.8 The Commission heard evidence that Grace appeared to love walking and she was reported to walk at an “*incredible*” or “*tremendous*” pace and for long distances. The evidence from the members of the Family X household and from the staff of Day Service Provider A corresponded on this point.
- 4.9 In his report of 27th November, 2001, reported upon in the Commission’s Second Substantive Interim Report, Mr. M recorded that “[Grace] *is very fit and has a super slim figure, this is down to all the walking she does. She loves walking and can walk for miles and miles at an incredible pace. She walks both at [Day Service Provider A] and at home.*”
- 4.10 Mrs. X described how Grace would sometimes go down on one knee to the ground when walking, describing it as being like a “*genuflect[ion]*” that she might do twice on either knee during a one mile walk. She said that it was a habit that Grace had and that no one had got her out of it.
- 4.11 Both Mr. M and CW2 recalled Grace as getting great enjoyment from cycling a tricycle at speed at Day Service Provider A. Mr. M described how she would rub up against walls and gates as she cycled and CW2 recalled the need to monitor her when she was using the tricycle. CW2 told the Commission that Grace did not get bruises or marks while cycling at Day Service Provider A because the staff there would make sure that the area that she was cycling in was kept clear.
- 4.12 Mr. M observed at the Commission that Grace was “*such a slight young lady*” and that, particularly with regard to the activities she undertook with Day Service Provider A, she bruised easily and “*put herself in danger.*”
- 4.13 It was evident from the accounts given at the Commission about Grace’s activities that she could be very physically active. This is relevant background context, when investigating her physical presentation over time and in connection with the query of physical abuse, reported upon in this Chapter. It is important to observe, however, that Grace derived enjoyment from these activities and that they were something from which she benefited. It should also be noted that Grace was not always so active, was sometimes quiet, and also participated in other less active pursuits in the day centre.

5. Sensory processing difficulties

- 5.1 As noted above, Grace also experienced sensory processing difficulties. In general terms, sensory processing is the ability of the brain to take in, sort out and process information and generate an appropriate and graded response. Difficulty with sensory processing happens when the brain cannot sort, filter, organise, analyse, connect or integrate sensory messages. Behaviours seen in connection with sensory processing difficulties include overactivity and/or underactivity, and sensory-seeking behaviour, e.g. touching objects/people excessively, squeezing people, chewing or smelling items. The behaviours in question also include oversensitivity to sensory input, difficulty concentrating and sitting still, anxiety and fear, withdrawal and avoidance, aggression, and “*shutdown*”.⁷
- 5.2 Dr. Ferrari, Consultant Psychiatrist with the Brothers of Charity, treated Grace following her move into the residential unit in July, 2009. Dr. Ferrari’s evidence concerning the impact of the move upon her is reported in Chapter 4 of this Volume.
- 5.3 In January, 2011, Dr. Ferrari recommended a sensory integration assessment in order to assess Grace’s sensory needs. This was prompted by the fact that, according to Dr. Ferrari, she appeared to have “*so many inappropriate sensory needs.*” There was no evidence, however, that this assessment was carried out.
- 5.4 In her evidence, Dr. Ferrari recalled how Grace’s constant forcefulness and pushing against people suggested to her that she might have “*some sensory problems in that area*” and that “*something could be done about it.*”
- 5.5 There were reports in Day Service Provider A of the benefit and the sense of calm that Grace got from using their multi-sensory room and this was confirmed by staff members who gave evidence to the Commission.

6. Grace’s experience of the bus

- 6.1 Up until the time that Grace started in Day Service Provider A in September, 1995 at 16 years of age, she had spent her days almost always in the company and care of Mrs. X, either at home or in the locality of Family X’s home. Before attending Day

⁷ National Council for Special Education, Demonstration Project on in-school and Early Years Therapy Support, “*Sensory Processing: Information for Parents*”.

Service Provider A, Grace had never travelled on a bus before on her own. Nor had she ever travelled anywhere on her own as she was not able to do so.

- 6.2 During the period from 1995 to 2009, on the days that Grace attended Day Service Provider A, she travelled to and from there by private bus, which was funded by the SEHB/HSE. The bus picked up a number of service users from different locations and the journey to and from Family X's house took approximately an hour each way. The Commission heard evidence that Grace was one of the first to be collected *en route* to Day Service Provider A.
- 6.3 Mr. M told the Commission that the bus usually carried approximately 15 passengers, both adults and children, with some being dropped off at two other facilities in Waterford City before reaching Day Service Provider A. He described how some of the *"more capable"* adults looked after the children on the bus. Mr. M observed that it was not the bus driver's job to act as a carer and that there was no helper or chaperone on the bus to calm things down or to intervene if some issue arose. Mr. M said that there were no seatbelts on the bus. Mr. H, the main bus driver who, from 2005, operated the bus throughout Grace's time in Day Service Provider A, suggested otherwise in his statement to An Garda Síochána (see below), stating that Grace *"would leave her seatbelt on but would jump at the window anyway"*. Accordingly, whether Grace wore a seatbelt throughout all of her time at Day Service Provider A was not clear. However, it appeared that this did not prevent issues arising on the journeys to and from Day Service Provider A. Mr. M also said that he saw the bus journey as a *"danger waiting to happen"*, there being *"quite a few very large characters, closeted together on a tiny [bus] for an hour, maybe an hour and a half more each morning, each afternoon"*.

Grace on the bus

- 6.4 The bus came to collect Grace in the early morning and returned her to the house of Family X in the evening. As mentioned already, the journey each way lasted around an hour. It is apparent that, from the beginning, Grace had a tendency to bang her head on the bus. Mr. H told Mr. M about episodes of Grace's head-butting the windows of the bus. Mr. M told the Commission that, in consequence, the bus driver stopped Grace from travelling on the bus for a period of time. Mr. M recalled that the bus driver *"would come in and say, 'listen, she has head-butted or she was attempting to strip off on the bus...'"* and that the bus driver would then speak directly

to Mrs. X, with the result that Grace might be “stood down” for a couple of days. In his Garda statement, Mr. H said that Grace never actually stripped off her clothes while on the bus.

The bus driver

- 6.5 Regrettably, Mr. H, whose oral evidence would have been of assistance to the Commission, passed away prior to its establishment.
- 6.6 However, in the course of its investigations into Grace’s case, an Garda Síochána took a statement from Mr. H with respect to his memory of her on the bus. Mr. H’s statement provides his first-hand account of travel on the bus for Grace, which was broadly reflected in the accounts given in evidence by Mrs. X and by Mr. M at the Commission.
- 6.7 In his statement dated 4th October, 2012, Mr. H described *inter alia* his interactions with Mrs. X and Grace and, in particular, Grace’s experience on the bus. His statement is set out in full as follows:

“My name is [Mr. H]. I was driving for [a local firm who] ran the Bus Service for the Health Board contracted to them. I started in 2005 and I finished up in 2010. My normal day started at 7.45am. I would then go and collect the Mentally/Physically Disabled People from starting [at a particular location, before moving on to the locality where Grace lived with Family X and thence to other localities] and then to [two workshops and] then to [Day Service Provider A] where [Grace] went. I would be over to [Day Service Provider A] home around 10am. Going then, I started at [Day Service Provider A] at around 3pm and went back the opposite way. I would get to [Family X’s] at around 3.45pm and finish at around 4.10pm. I know [Mrs. X] very well and have done since I started the driving. A lady [she] is, everything is above board with [her]. [Grace] would be stuck to [Mrs. X] like glue everyday. [Mrs. X] would bring her out [to] the bus very morning and collect her. [Grace] would be dressed immaculate[ly] and hair done well but the kids would be tearing their hair out at times. Some mornings [Mrs. X] would tell me that [Grace] was sick and not going. She would go fairly regularly on the bus but when she was missing,

not going, it could be for a week but I think that's not unusual as a lot of those people with disabilities would be sick and pick up sickness especially in the winter. [Grace's] behaviour on [the] bus was erratic. Some days she would be quiet but other days she would scream or rock in her seat and I knew that then she was going to throw herself at the window, she would do it a bit everyday. She would do this quite hard. I had to stop the bus a good few times to stop her. She would have marks on her head, mostly off her forehead but the red mark would be gone after a while, sometimes the marks would stay on her head. I never really looked because her hair would be down and I was driving the bus but I knew when I heard the screech, I knew it would happen but I couldn't do anything for her. I tried to put someone inside her at the window but she used to jump over them to hit the window with her head. [Grace] would leave her seatbelt on but would jump at the window anyway. I don't remember any marks or bruises or scratches on her. I remember seeing her banging her head at [Day Service Provider A] as well [as] on the bus. She used to get excited when she saw the bus in the evening, she [would] be rocking in and out but when she went to Residential [care] I didn't see her at all. I said it to [Mrs. X] a good few times about her banging her head on the bus, I didn't say it to the people in the Residential because they saw her do it as I did. [Grace] when with me never stripped off her clothes on the bus, only banging her head. She was hard to deal with on the bus. Those kids, most of them went to [a different school] up to the age of 16 and they'd have a Carer on the bus to help. When they go above 16 and the kids I had were over, there was no Carer [supplied]. Some mornings there'd be chaos on the bus, some mornings there wouldn't be, others would punch others on the bus, it was very frustrating. I wouldn't do it again, the roads were bad and trying to concentrate was hard. I want to clarify that I didn't see any cuts, bruises or marks on [Grace] coming from [Mrs. X's] house, definitely not. As you informed me that on 20/8/08, [Grace] went to the A & E, Waterford with a bruise under her right eye. I don't recall this at all. All I will say is that [Grace] used to bang her head but mainly on her forehead. [Another man] had the contract first but lost it after a year I think and [another man, my employer] took it on and I stayed driving for him. I don't know who was driving before me and I was driving up

to the time that [Grace] left [Mrs. X]. [Mrs. X] was heartbroken over it. I never seen a woman so low in all my life. I also knew [Mrs. X's] nephew. [Gamma]. I think he did [a specified job]. I would meet him there some days. There was another fellow living out the back...but I don't know his name. From what I could see [Grace] was stuck to [Mrs. X], she would bring her out every morning and [Grace] would run to her off the bus. [Mrs. X] rang me for a week after it, broken hearted. I was never off sick in that time. When one place was going on holiday, the other would be coming back from it so I was constantly going. This statement has been read over to me by [a specified Garda]. I have been asked to make any alterations or changes I deem necessary. I do not wish to do so."

- 6.8 The Commission also heard evidence relating to Grace's experience on the bus and the situation on the bus as relayed by the bus driver to others. These ranged from what the bus driver reported to Day Service Provider A and to Mrs. X, as well as what he said to Mrs. X's nephew, Gamma.
- 6.9 Similar to Mr. H's statement, Mr. M said that attempts were made to seat someone between Grace and the window of the bus, but that she then started head-butting other people, which he described as "awful". At the beginning of Grace's time at Day Service Provider A, Mr. M also recalled trying for a couple of weeks to get her to listen to music on headphones in an attempt to pacify her, at the end of which period the CD player was so damaged that it would not play music anymore.
- 6.10 As regards other service users' accounts of Grace's behaviour on the bus, Mr. M said that they would tell him that she was "bold" on it but that they would not go into any further detail than that.
- 6.11 CW1 told the Commission that a number of service users had issues in relation to transport to Day Service Provider A and that such difficulties were not exclusive to Grace. CW1 said that Mrs. X had occasionally written notes to Day Service Provider A about things that had happened on the bus that the staff of Day Service Provider A would not otherwise have known about, other than through talking to the bus driver.
- 6.12 Records disclosed to the Commission show that there was an incident of such behaviour on 4th February, 2000, when CW1 wrote that "[Mrs. X] rang to say that

[Grace] *wasn't in today because she + [Mr. H] had decided that [she] wouldn't go on the bus today...* [Grace] *wasn't on the bus today because yesterday she was banging her head off the bus window + [Mr. H] was afraid for her on the bus. [Mrs. X] explained this banging as part[ly] due to [Grace's] period."*

- 6.13 In giving evidence before the Commission, CW2 also recalled being aware that Grace used to bang her head off the window of the bus and Mrs. X's contacting Day Service Provider A to inform them when it occurred. CW2 recalled how the bus driver also informed Day Service Provider A staff of such incidents because, she said, he was concerned for her safety and that of the other service users. She said that the service users also told her when Grace engaged in head-butting on the bus. CW2 recalled, in particular, how the bus driver mentioned that the other service users on the bus would get excited when Grace banged her head and would try to stop her, which would only excite her even more. CW2's understanding was that the bus driver was having general difficulties in controlling the service users on the bus and that it was not an issue that was exclusive to Grace.
- 6.14 Commenting on the above entry made by CW1 from 4th February, 2000, Mr. M said that she was perhaps being "*diplomatic*" in saying that it was Mrs. X and the bus driver, as opposed to just the bus driver alone, barring Grace from the bus.
- 6.15 As reported above, both CW6 and CW7 recalled that Grace banged the side of her head against the bus window.
- 6.16 In giving evidence before the Commission, CW5, who worked as a care assistant at Day Service Provider A from 2004 to 2007, said that she believed that Mrs. X saw the bus as a "*difficulty*" for Grace and she recalled Mrs. X's bemoaning the time that she had to spend on the bus travelling to and from Day Service Provider A, all "*for the sake of a couple of hours*". She also vaguely recalled other service users saying that Grace was "*bold*" on the bus.
- 6.17 Ms Leyshon, Social Worker for Adults with Intellectual Disabilities from February, 1999, and who remained Grace's SEHB designated key worker until 2001, also gave evidence of having been aware that Grace encountered difficulties while travelling on the bus, and she thought that she had spoken to Mr. M about some incidents, including Grace's banging her head on the bus. She said that she would not have been surprised to hear that Grace was banging her head, given her intellectual

disability. Ms Leyshon thought that she might have learnt at the time that another service user on the bus had been “*getting at*” Grace from time to time.

- 6.18 Ms D also recalled Day Service Provider A’s receiving reports from the bus driver that Grace banged her head, as well as from day centre staff who informed her that she sometimes banged her head when she was out on Day Service Provider A’s own bus.
- 6.19 Mrs. X recalled being aware of Grace’s behaviour on the bus and of the bus driver’s reaction to that. She said that on Tuesday evenings in particular, the bus driver would tell her that she was “*driving [him] mad*” because she was banging her head so much. Mrs. X said that, based on what she was told, Grace used to come behind Mr. H and bang her head and would not stop. Mrs. X said that Grace used to “*go up and down*” and bang her head and that, several times, she came home with “*lumps*.” She recalled Mr. H’s being “*really scared*” and said that, when she asked two of the men who travelled on the bus if the situation was really so bad, they responded that it was, saying “*yeah, we tried to stop her and we can’t*.”
- 6.20 Mrs. X recalled that Mr. H, whom she said was “*really scared*”, wanted a helper on the bus but that, while they tried and Ms Kathleen O’Sullivan, Nurse Counsellor for Parents of Children with Mental Disabilities / Advisory Nurse for the Mentally Handicapped, promised to get one, the HSE refused. She said that Ms O’Sullivan also promised seatbelts. Mrs. X told the Commission that Ms O’Sullivan came out to her and informed her that she was getting a harness for Grace so that she could be strapped in to the seat on the bus. However, as reported in Chapter 6 of the Commission’s First Substantive Interim Report, Ms. O’Sullivan said that she did not believe that either of those issues would have been within her remit and that they would have been a matter for an occupational therapist or the transport provider to address. She believed that Mrs. X’s evidence in relation to the harness was “*untrue and inaccurate*”. The Commission cannot be satisfied on the evidence that Ms O’Sullivan did tell Mrs. X that she was getting a harness for Grace. As is also reported in Chapter 6 of the First Substantive Interim Report, Mr. M told the Commission that the driver had no helper on the bus, despite this being regularly requested of the health board by Day Service Provider A. Mr. M told the Commission that he had asked for a helper “*umpteenth times*”. He said he raised the matter verbally with different people in the health board and had a meeting with the health board about the issue. Mr. M was not challenged on this evidence. As concluded in the

First Substantive Interim Report, transport for Grace was arranged with regard only to the practical consideration of transporting her to and from Day Service Provider A. There was no provision by the health board for an assistant or helper to support her on the bus over this period. Grace was simply expected to manage this on her own.

- 6.21 Mr. M recalled that he had telephone conversations with Mrs. X regarding Grace's injuries and he said that she knew that the incidents referred to above were happening on the bus. He told the Commission that he approached the conversations with Mrs. X on the basis that the incidents were happening on the bus because that was what the bus driver was telling him. Mr. M said that everybody was of the view that this was happening on the bus.
- 6.22 The picture that emerged from the evidence to the Commission was that the bus to and from Day Service Provider A could be somewhat chaotic. The Commission is satisfied from the extensive evidence examined on this issue that it regularly presented a challenging environment for Grace. It was evident that her experience of travelling by bus varied and that, clearly, some days were better or quieter than others.
- 6.23 The Commission is satisfied that the nature of the evidence with respect to Grace's travel on the bus to and from Day Service Provider A was such as to point to the likelihood that she could, on occasion, suffer minor injuries in the course of her journeys.

7. Grace's incontinence

- 7.1 Urinary incontinence and faecal incontinence were issues that Grace endured from a young age, preceding her placement in foster care with Family X at the age of ten. Grace was not toilet trained before her placement with Family X. The report of the Sister-in-Charge at Grace's school, dated 27th January, 1989, one month prior to her moving in with Family X, observed as follows:

"TOILET TRAINING.

In nappies all the time, doubly incontinent. Has frequent bouts of diarrhoea. Usually has more than three motions per day. On toilet training programme. Uses toilet when seated."

- 7.2 It is apparent from the evidence that Grace's incontinence and its management was an ongoing challenge for Mrs. X. Grace had to be changed frequently, and regularly had to use incontinence wear at night. Attendance to her personal hygiene was inevitably required during the day as a consequence.
- 7.3 Grace's incontinence was also an ongoing issue in connection with her attendance at Day Service Provider A. In particular, she had regular episodes of incontinence on the bus on the way to Day Service Provider A and needed to be changed and showered when she arrived there when this happened. Grace also had episodes of incontinence and soiling during the day in Day Service Provider A.
- 7.4 The Commission also heard evidence that skin rashes sometimes observed on Grace were attributed to her use of incontinence wear.
- 7.5 Grace had to be prompted to go to the toilet, both at home and in Day Service Provider A, at allotted times during the day. For instance, arrangements were made so that she would go straight from the bus into the toilet on arrival at Day Service Provider A in the morning. She was taken to the toilet after the meal in the middle of the day and again before she left for home.
- 7.6 In addition to the above allotted times, Mr. M told the Commission that the staff at Day Service Provider A had to anticipate the need for Grace to use the toilet, for instance when she became restless or looked as if she needed to go to the toilet. Staff at Day Service Provider A recalled how, when asked if she needed to go to the toilet, Grace complied but sometimes remained in the toilet cubicle longer than was necessary and needed to be told to come out. Grace needed help cleaning herself and staff assistance was accordingly required whenever she used the toilet.
- 7.7 CW2 recalled how Mrs. X would be displeased if Grace wet herself and that the staff of Day Service Provider A brought her to the toilet frequently in order to try to stop that from happening. CW2 said that despite their efforts, Grace did unfortunately wet herself from time to time.
- 7.8 Mr. M said that "*unfortunately*", when Grace needed to be changed after an episode of incontinence, staff had to dress her in clothes that belonged to Day Service Provider A, rather than her own clothes. Mrs. X sent underwear in with Grace, he said, but her outer clothes got soiled as well. Mr. M told the Commission that Grace's

own clothes would then be washed overnight at Day Service Provider A and dried in the morning and returned to Mrs. X. He said that this situation, whereby Grace was wearing clothes that were not her own, was not unlike other service users but that it caused some agitation to Mrs. X. Mr. M gave evidence that Mrs. X asked that Grace not be dressed in clothing that was not her own and that Day Service Provider A staff attempted to explain to her that, in the absence of her having extra clothes with her, they had no other option. Mr. M said that Mrs. X washed and returned any clothes that Grace borrowed from Day Service Provider A.

- 7.9 Separate to the issue of Grace's wearing clothing that was not her own, CW2 recalled that her wetting herself was an issue in itself for Mrs. X. CW2 gave evidence that Grace, like other service users, was taken to the toilet before outings in order to avoid her wetting herself, adding that longer trips presented more of a difficulty. Referring in particular to a note of an incident when Grace had wet herself while out on a day trip from Day Service Provider A, CW2 told the Commission that, while they did give Grace the opportunity to use the toilet, Grace liked to drink tea and had obviously needed to go to the toilet again on this occasion and unfortunately been incontinent of urine. She said that *"it just happened [with Grace]"*.
- 7.10 Daily records kept by Day Service Provider A recorded that, on 29th June, 1999, Mr. X complained to Mr. M that Grace was going home wet and in a different change of clothes every day. The notes recorded Mr. M as saying that he did not feel that this was accurate.
- 7.11 CW2 gave evidence of Mrs. X's having told her that Grace did not wet herself at home and that she only used incontinence wear at night-time. CW2 told the Commission that Mrs. X was *"very adamant"* that Grace should not have been wetting herself in Day Service Provider A and *"hated"* when it happened. According to CW2, the situation became so difficult that, if Grace was incontinent, the staff would wash and dry her clothes in the same day so as to avoid causing annoyance to Mrs. X.
- 7.12 Referring to a letter written by Mrs. X to Nurse N of Day Service Provider A dated 25th September, 1998, Mr. M said that Mrs. X, in trying to be helpful and in trying to overcome the problem of Grace's wetting herself, decided in Grace's best interest that she would put incontinence wear on her before she got on the bus and asked that she be changed into her underwear on her arrival at Day Service Provider A.

- 7.13 Records disclosed to the Commission showed that there was ongoing communication between Mrs. X and Day Service Provider A in late 1998 in connection with Mrs. X's concerns that Grace had resumed wetting herself or soiling herself, either at Day Service Provider A or when she was travelling on the bus to and from it. The documents indicate that Mrs. X was worried about the length of the bus trip in the absence of a toilet being available to Grace and generally about her not getting to the toilet on time and having to come home in different clothes. She was concerned about Grace's incontinence and about keeping it under control. The Commission is satisfied on the evidence that Mrs. X sometimes managed to get Grace's incontinence under control as in when she could take her to the toilet regularly at home. It was, evidently, a difficult ongoing care issue.
- 7.14 Grace continued to be incontinent and to require incontinence wear following her move from Mrs. X's care in July, 2009.

Finding

- 7.15 The Commission is satisfied on the evidence considered above that Grace is likely to have had rashes and marks on her skin associated with her using incontinence wear from time to time.

8. Record keeping

Prior to February, 1989

- 8.1 By the time Grace was placed in foster care with Mrs. X in February 1989, she had been the subject of assessments and reports regarding her level of disability and the challenges these presented for her and her carers in her day-to-day care. These assessments and reports are considered in the Commission's First Substantive Interim Report, which can be read with this Volume of the Commission's Final Substantive Report.

Records with respect to Grace

February, 1989 to October, 1995

- 8.2 The Commission is satisfied that there is nothing in the notes and records maintained by officers of the SEHB involved in Grace's case or by the doctors and psychologists

who assessed her during the period between her coming into foster care with Family X in 1989 until she started at her day placement in Day Service Provider A in September, 1995, about any concerns having been raised that she was the subject of physical abuse.

- 8.3 The Commission's investigation into the management of Grace's case from 1989 to 1996 has been reported upon in the First Substantive Interim Report. All relevant reports and records with respect to her over that period, concerning her management and her care, are detailed in that report. The First Substantive Interim Report should, as stated above, be read in conjunction with this Chapter.
- 8.4 There were no issues of concern raised in the extensive records and documentation disclosed to the Commission about Grace's care or as might tend to suggest that she was being physically abused in her placement over the period from 1989 to 1996. Further, there was no evidence provided to the Commission that Grace's physical welfare gave rise to any question or concern within the SEHB of physical abuse of her over that period. The First Substantive Interim Report contains the Commission's findings with respect to the deficits in the care and management of Grace's case by the SEHB, including the failures in the monitoring of her care over the period that she was a foster child in the care of Family X. Given those deficits, the fact that no concerns were raised or identified by the SEHB over that period with regard to the question of whether Grace might be subject to physical abuse is somewhat limited in its evidential value. Nonetheless, the Commission takes into consideration the fact that the SEHB personnel who saw Grace during the years from 1989 to 1996 (as reported in the First Substantive Interim Report) did not have concerns that she was being physically abused in her placement.
- 8.5 Mr. M's report of 4th April, 1996 contained the earliest reference in the records disclosed to the Commission to Grace's having scratches or bruises. As reported upon in the First Substantive Interim Report, that report was prepared by Mr. M at the SEHB's request and contained an account of Grace's experience over the first seven months of her time in Day Service Provider A. Mr. M was not told why the report was sought. He understood that he was being asked for an update in relation to Grace's progress and as to whether the trial period she had been on in the day centre was going to be extended. In fact, the report had been requested in circumstances where the SEHB had decided to remove Grace from her placement. Mr. M's report is referred to further below.

- 8.6 The Commission considers that it would be an unrealistic approach to the evidence about Grace to consider her to have been a child or young person who never sustained a bruise, a scratch, a mark, or an injury of any kind before records of any such matters were made or noted in the context of her attendance at Day Service Provider A from September, 1995. Such an approach to the evidence would ignore the realities of everyday life for any child or young person, let alone a child or young person with Grace's difficulties and vulnerabilities. In this regard, the Commission observes that the everyday occurrence of marks, bumps and bruises associated with growing up are rarely, if ever, catalogued. An assumption that Grace reached the age of 16 without suffering minor injuries of the kind described above is not, therefore, one that the Commission makes.

October, 1995 to July, 2009

Day Service Provider A Records

Preliminary

- 8.7 Day Service Provider A had a system in place whereby a Daily Report Book or Daily Report Record was maintained to document how all service users attending the day centre got on during the day, the activities that they did and how they ate or drank. This was also used to note down and keep a record of anything of potential concern.
- 8.8 Mr. M told the Commission that, when Grace first started attending Day Service Provider A, she had a scratch of some sort that Mrs. X said must have happened there. Mr. M said that, arising from that, he gave a direction that Grace was to be examined by Day Service Provider A staff when she arrived in the morning so that they would be in a position to tell Mrs. X whether or not marks or scratches had been caused during the day. Mr. M acknowledged in evidence that he did this morning check with respect to Grace only, and not in relation to any other service user. This practice on the part of the staff of Day Service Provider A of checking Grace on arrival is reported upon in Chapter 6 of the Commission's Second Substantive Interim Report.
- 8.9 Mr. M told the Commission of the normal flow of daily communication within Day Service Provider A. He explained that Day Service Provider A was such a small place, and that every time he passed someone, he was discussing issues. Mr. M said that, even in the afternoon, when people came to the office to sign off and were

exhausted from the day, they were still discussing matters that had happened and that other people were then getting involved in the conversation. The paperwork, he suggested, was not always as important as contact with staff.

- 8.10 Mr. M said that information at Day Service Provider A was passed up the line through constant informal contact that they had through meeting either Nurse N or other staff in the morning. That was achievable, he said, because Day Service Provider A was small. Mr. M explained that he did not miss much; he could hear everything. Things did not have to be specifically reported. He said that he knew about them, because he “*was there.*”
- 8.11 The Commission is satisfied on the evidence from Day Service Provider A’s care staff and Mr. M that, in addition to being able to say to Mrs. X what the position was with regard to the occurrence of marks or scratches to Grace during the day, the other reason for checking her in this way was in the context of monitoring her well-being in the day service and looking at any welfare concerns that might arise with respect to marks or injuries noted.
- 8.12 CW2 recalled being told during Mr. M’s tenure as manager at Day Service Provider A to be extra vigilant with respect to Grace. Her recollection was that there was an “*air of concern*” around Grace, even when she first started at Day Service Provider A. CW2 did not know why she was asked to note bruises and marks on Grace on her arrival, but she was aware that Grace sometimes scratched herself at Day Service Provider A.
- 8.13 Record keeping in Day Service Provider A was generally sporadic until in or about 1998/1999, when its record keeping improved. By that stage, the Commission heard, a written note was kept of any mark or bruise noted on any service user.
- 8.14 A second type of book was used for service users, designed to enable communication between the service users’ families/ carers and Day Service Provider A. This included notes and communications between Day Service Provider A and Mrs. X, and sometimes Mr. X, with respect to day-to-day matters with regard to Grace’s care and her attendance.
- 8.15 Body charts, which comprised a diagram of a person on which marks or physical injuries could be drawn and notes made, appear to have come to be used as part of

Day Service Provider A's record keeping for service users from in or around 2007. Spots and blemishes were also recorded. Notes made in body charts were co-signed by two members of staff.

Record keeping from 2007

- 8.16 When Grace's case resurfaced for attention within the HSE and Mr. Smith became involved in her case, Mr. Smith requested Day Service Provider A to record any mark of any kind *whatsoever* observed on her because of his concerns about her in her placement on foot of his review of her case.
- 8.17 Ms D told the Commission that it was generally the care staff or programme assistants, as distinct from management, who wrote up the notes in the service users' Daily Report Record. She said that there was to be a daily entry and that these notes were often extremely brief if there was nothing to report. Ms D recalled how, during her first conversation with Mr. Smith, he asked her to take a note of any mark of any description seen on Grace and to convey the details to him.
- 8.18 Ms D told the Commission that, generally, any concerns regarding matters recorded in the body charts were brought to her attention but that she did not read individual Daily Report Records as a matter of routine, explaining that there were 35 service users being cared for at Day Service Provider A. She was, she said, relying on staff to bring any matters of concern to her attention.
- 8.19 With the assistance of the above records, the Commission was able to examine the circumstances of each documented injury which took the form of bruising, scratches, marks, or scrapes recorded in the notes, body charts, records and reports disclosed to it concerning the years reported upon in this Chapter. The Commission also took account of the wider evidence taken by it from witnesses and through Garda statements regarding the circumstances of any marks or injuries and their possible causes.
- 8.20 It is a statement of the obvious that these records only assisted for the days upon which Grace attended her day placement. Her level of attendance varied considerably over the years and, as mentioned above, she had many extended periods of absence from it.

- 8.21 The issue of Grace's absences from her day placement is considered and reported upon in Chapter 3 of this Volume.

9. Recorded incidents of marks or bruising to Grace

- 9.1 The notes from Day Service Provider A for the years between 1995 to 2009 reported upon in this Section of this Chapter are confined to those that recorded any injuries observed on Grace. Other notes with respect to Grace concerning other matters over this time, are reported as appropriate in other chapters in this Volume, where relevant.

The period from 1995 to 1999

- 9.2 Grace started attending Day Service Provider A on 4th September, 1995 and experienced significant difficulties in adjusting to this enormous change in her life. The chaotic nature of her presentation over her early days was catalogued in Mr M's report of April, 1996. This report has been reported upon in the Commission's First Substantive Interim Report and is referred to further below.

The year 1995

19th October, 1995

- 9.3 A note from Day Service Provider A dated 19th October, 1995 stated, *"while toileting [Grace] in AM, Large bruise noticed on left hip appears tender to the touch. Bruises noticed are on Left elbow & Right elbow. Just visible & not tender to touch. In good form."*

Cause or explanation

- 9.4 The cause of this bruising to Grace's left hip and her elbows in October, 1995 was not established by the staff of Day Service Provider A at the time. There was no evidence of discussion with Mrs. or Mr. X or with the bus driver about it. Mr. M told the Commission in evidence that while this bruising concerned both him and Nurse N and that they monitored the situation, he felt that it could be put down to the sort of knocks that Grace could get from time to time, because of how she was and how she behaved on the bus. He said that, at the time, he and Nurse N probably did query as

between themselves whether this bruising could have been “*self-inflicted from the bus...or boisterousness*”.

- 9.5 In this regard, although not referable specifically to this note, Mr. M told the Commission that it was not unusual for people who attended the day centre to get cut knees, bruises, and lots of other things. In this regard, he described how:

“People getting knocks and grazes [was] not unusual...People fell, people head-butted the wall or the window. So we did have cut knees and bruises and lots of things.”

Finding

- 9.6 The evidence to the Commission did not identify the particular circumstances as to how or where this bruising had been sustained. The Commission considers that there is no evidence that supports a finding that the bruises identified in October, 1995 arose because of physical abuse of Grace. The Commission is satisfied that the general evidence of Mr. M, considered in conjunction with the context outlined above, pointed to the likelihood that this bruising was accidentally sustained and at the very least, this is not a possibility that can be reasonably ruled out.

15th November, 1995

- 9.7 On 15th November, 1995, Nurse N, who at one time was the acting manager of Day Service Provider A, wrote a note to Mrs. X stating that she “[n]oticed a bruise on (It) side [Grace’s] cheek bone under eye. Just in case you might think it happened here, a very slight one on other side”.
- 9.8 Day Service Provider A’s records for this date showed that Grace was also suffering from gingivitis, very sore gums, and bleeding from the mouth on this date.
- 9.9 This note was sent by Day Service Provider A to Mrs. X by way of a letter. As outlined above, the purpose of sending the note to Mrs. X was to let her know what had been observed at Day Service Provider A, so that it would not be taken as having happened there.

- 9.10 Mrs. X wrote back thanking Nurse N for her letter, stating, “[w]e noticed the marks on [Grace’s] face when she got off the bus but [we] had concluded something may have happened on the way home. However it seems to be clearing up nicely now. No way did we think it may have happened in the [day centre].”

Cause or explanation

- 9.11 Mr. M told the Commission that he did not know what Nurse N was alluding to in the note.
- 9.12 With reference to Mrs. X’s response, Mr. M told the Commission that this would probably have prompted him and Nurse N to question the bus driver as to what he saw or heard on the bus but that the bus driver was likely to have said “*anything could happen back there*”. He did not, however, have a specific recollection of having made such enquiries.
- 9.13 During her evidence, Dr. Walsh was asked for her professional view as to whether the reply which Nurse N had received from Mrs. X would be sufficient to close the matter. She observed that, while they might well be easily explained, marks of that kind on Grace’s face would ordinarily merit a follow-up, saying:

“[O]ne would need to look at it in the broader sense that one would need to follow up for instance if, say, it hadn’t happened in [Day Service Provider A] and hadn’t happened in the home, was there a difficulty on the bus, you know? Did the young person fall off the seat on the bus? Was there a problem with her head-butting or was there other young people on the bus, you know, who may have caused difficulty for her? It does merit looking at it.”

- 9.14 There was no further evidence specific to this entry available to the Commission in its investigations.
- 9.15 According to the records disclosed to the Commission, neither the staff of Day Service Provider A nor Mrs. X knew at the time how this bruising had been caused to Grace. Mrs. X seems to have thought at the time that it might have occurred on the bus and Mr. M gave evidence that he and Nurse N were likely to have made enquiries with the bus driver at the time. There was, however, no evidence available

to the Commission about the details of Grace's bus journeys over the days concerned. Even so, there was ample evidence, as reported at Section 6 above, about the extent of her difficulties and self-injurious behaviours on the bus.

- 9.16 In her evidence to the Commission, Mrs. X said that she did not remember any conversations with Day Service Provider A personnel about injuries happening to Grace on the bus. Nor could she recall telephoning Day Service Provider A in the first six or seven months of Grace's attendance there. She said that she had a good relationship with both Mr. M and Nurse N. This was confirmed by Mr. M in his evidence to the Commission.

Finding

- 9.17 The indication at the time that Grace had marks coming off the bus was in keeping with the evidence as to her difficulties with head-butting on the bus around this time. The Commission considers that the likelihood is that she sustained this injury in the course of travelling on the bus. At the very least, in the absence of evidence concerning the specific dates in question and having regard to the evidence of Grace's self-injurious behaviours and the difficulties that she regularly encountered on the bus as outlined in Section 6 above, this is not a possibility that can be reasonably ruled out. There was no evidence to support a finding that these marks arose because of a physical assault or physical abuse of Grace by any person or persons.

The year 1996

Bruising referred to in Mr. M's report of April, 1996

- 9.18 Approximately seven months after Grace's arrival in Day Service Provider A, Mr. M was asked to prepare a report on her, the details of which are set out in full in the Commission's First Substantive Interim Report.
- 9.19 Mr. M told the Commission that he did not have any concerns regarding Grace at that stage but added that the report would have been seen by social workers in the SEHB who could have advised if there was anything of note. He said that he was "*passing that [information] up*" so that the social workers would be aware of it and come back with their own thoughts, if necessary.

- 9.20 The report, which related to the first seven months of Grace's attendance at Day Service Provider A, included the following paragraph:

"On several occasions when she [Grace] was being bathed at our centre, bruising was noticeable on her body. These bruises were brought to the attention of the foster parents, they informed us that they couldn't account for these bruises and said they must have happened when she was on the bus.

The foster parents communicated with us by letter rather than by 'phone. We had a very good relationship with [Mr. & Mrs. X]"
(emphasis added).

- 9.21 After referring to the difficulties encountered by Grace and the management issues in taking care of her at Day Service Provider A during the initial seven month period, Mr. M concluded his assessment on a positive note, saying:

"Overall [Grace] has made remarkable improvements...Obviously after confinement at home, she was unaccustomed to dealing with an environment like ours. She now appears more happy and content in herself."

- 9.22 Mrs. X could not say whether Grace's behaviour had improved following the initial seven month period, as Mr. M had said in his report, but she thought that that probably did happen.

Cause or explanation

- 9.23 There was no further evidence of notes being sent to Mrs. and Mr. X about bruising on Grace in the period up to the date of Mr. M's report in April, 1996, other than as set out above.
- 9.24 Mr. M was unable to recall during his evidence to the Commission the number of occasions, referred to as "several" in his report, on which bruising had been observed while bathing Grace. Nor did Mr. M recall the nature of the bruising involved.

- 9.25 When asked if Mrs. X ever remembered bruises on Grace's body being brought to her attention by someone at Day Service Provider A, Mrs. X said that she only recalled something about a bruise to her eye.
- 9.26 There was no other evidence available to the Commission with respect to the "*several occasions*" on which bruising was observed, as referred to by Mr. M in his report.
- 9.27 In addressing the issue of the significance of bruising and marks to Grace throughout his evidence to the Commission, Mr. M reiterated the difficulties experienced with her self-injurious behaviour, her high level of activity and physicality, and the problems for her when travelling to and from Day Service Provider A on the bus. The difficulties encountered by Grace regarding each of these aspects of her life was substantially borne out in the evidence examined by the Commission. The issue of bruising was a matter of concern for Mr. M, as recorded in his report for the SEHB on Grace's progress. The concerns about Grace in the assessment of her first seven months attending Day Service Provider A painted a picture of a difficult period of adjustment for her in adapting to the very significant change in her daily life brought about by her commencing attendance at a day placement facility at the age of 16.
- 9.28 The reason suggested for bruising to Grace, referred to in Mr. M's report as having happened on the bus, was not looked into any further at the time. The Commission observes that, on the evidence, the ongoing difficulties on the bus were a real source of hazard for Grace. Some of the difficulties encountered by Grace on the bus at the time are documented in Mr. M's report, as are her overall behavioural difficulties over her initial seven months at Day Service Provider A.
- 9.29 The optimistic conclusion to Mr. M's report and his satisfaction regarding the nature of communication with Mrs. and Mr X. was in accordance with his view at the time that the challenges and difficulties encountered by Grace on starting at Day Service Provider A were being appropriately managed in Day Service Provider A. The entire focus of the staff of Day Service Provider A was upon helping Grace to settle in. Mr. M, although concerned that Grace had bruising, was not dissatisfied at the time with the explanation offered by Mrs. X that it might have happened on the bus. His views in that regard did not change in hindsight at the Commission.

Findings

- 9.30 The evidence to the Commission did not identify the particular circumstances as to how or where observations of bruising, referred to in Mr. M's report, had been sustained. The view offered by Mrs. X and Mr. X at the time, that the bruising must have happened on the bus, was not inconsistent with the evidence with respect to Grace's difficulties on the bus. The Commission considers that the likelihood is that Grace did sustain some of this bruising in the course of travelling on the bus to and from Day Service Provider A over this period. Given the nature of bruising generally, clearly and in the ordinary course of events, this would become visible some time after the event which caused it.
- 9.31 The possibility that Grace sustained some of the bruising noted during her day-to-day life at home over this period cannot be entirely excluded on the evidence. However, there was no contemporaneous information to indicate that the specific instances of bruising to Grace had occurred other than on the bus, and the Commission was not provided with any contrary information. There was also no evidence to support a finding that these marks arose as a result of the physical assault or abuse of Grace. The evidence of such bruising did not of itself, and in the absence of further evidence, lead to such a conclusion. On the contrary, in considering the evidence with respect to context outlined above, the Commission is satisfied that the likelihood is that this bruising was accidentally sustained, rather than inflicted by physical abuse.

Absence of notes or records for the year 1996

- 9.32 Chapter 7 of the First Substantive Interim Report has reported on the events that occurred in 1996 with respect to the management of Grace's case specifically, the communications throughout that year between the SEHB and Mrs. and Mr. X, and the communication between the SEHB and Day Service Provider A in connection with such matters. Both that chapter and Chapter 8 of the First Substantive Interim Report contain the Commission's report on the Terms of Reference set for its inquiries into the management of Grace's case over that year and form a considerable part of the Commission's First Substantive Interim Report.
- 9.33 Grace was 18 years of age in November, 1996. As reported upon in detail in Chapter 7 of the First Substantive Interim Report, the decision made within the SEHB in early 1996 to move her from her residence with Family X into an institutional residential

placement was reversed by October, 1996, and the SEHB decided that Grace was to continue to attend at Day Service Provider A.

- 9.34 There were no notes or records of any physical injuries or any concern about physical injury to Grace in the course of 1996 contained in the extensive documentation disclosed to the Commission by the HSE, or on behalf of the local voluntary association or Day Service Provider A.

The year 1997

- 9.35 On 8th January, 1997, Mr. M made a note of some marks on Grace's face, on both her ears, below her left eye on the cheek, on her chin, and on her back. CW2 and CW8 made a full body examination and noted further scratches on her lower body.

- 9.36 Mr. M noted as follows:

"...at 10.35 hrs When [Grace] arrived at [the day centre] her bus driver...informed us that he had not noticed any scratches on her face. He also related that [Mrs. X] had taken away her 'keys' because she had been scratching herself. [CW2] and [CW8] made a [full] body examination and found further scratches on her lower body. [Grace] appears very calm considering she is without her 'soothing keys'. After the examination I called [Mrs. X] and informed her about all the scratches that had been discovered. She explained that [Grace] is going through a particularly bad bout of acne and is forever scratching. The girls who examined [Grace] washed the blood from her ears and face. We also spoke about yesterday's incident when [Grace] soiled herself."

Cause or explanation

- 9.37 Mr. M did not have a specific recollection of these injuries to Grace when giving evidence to the Commission. He remembered "various" occasions, without remembering specific ones, attributing this to the passage of 21 years since they had occurred.

- 9.38 CW2 also could not remember observing these marks on Grace or the events of 8th January, 1997 specifically. Her evidence with respect to Grace's scratching herself has been reported at paragraph 3.53 above.

Finding

- 9.39 The Commission is satisfied that, bearing in mind the irritation caused by the acne that Grace suffered from and also her tendency to scratch her skin, the most likely explanation for these marks on Grace was that they were caused by her scratching herself. There was no evidence to support a finding that these scratches occurred because of a physical assault or physical abuse of her by any person or persons.

The year 1998

February, 1998

- 9.40 During a conversation with Ms Leyshon in February, 1999, Mr. M told her that Grace had had a black eye the previous year and that Mrs. X had insisted that it had not occurred at home. There was, however, no record of this black eye in the documentation from Day Service Provider A relating to 1998 and therefore no record of the circumstances noted at the time or the precise appearance of the injury.
- 9.41 Mr. M recalled this black eye when he gave evidence at the Commission. He said that the staff of Day Service Provider A or the bus driver had to account for it and he thought that it had been attributed to Grace's head-butting on the bus. Mr. M told the Commission that, at the time, "[Grace] was specifically doing a lot of head-butting on the bus and [that they] were trying to rearrange the [seating]." He said that Mrs. X was probably correct in saying that the black eye was not there when Grace left home, but he said that the bus driver was not a trained carer and would not have been looking for marks on Grace when she was getting on the bus in order to protect himself.
- 9.42 Mrs. X was confused and jumbled in her evidence in relation to this incident. Ultimately, it was apparent to the Commission that she conflated a black eye noted in 2008 with the black eye noted in 1998. Her evidence on this incident was, therefore, not of assistance to the Commission.

Finding

- 9.43 The Commission considers that, on the evidence of Mr. M, the incident that caused Grace to develop a black eye could have occurred while she was travelling on the bus or when in Day Service Provider A, or at home, having regard to her problem with head-butting noted at this time. There was no evidence to support a finding that this black eye arose because of a physical assault or physical abuse of Grace by any person or persons.

20th August, 1998

- 9.44 A handwritten note dated 20th August, 1998 recorded that another service user had pulled Grace's hair on the bus and was *"at her."* It noted that this young man tried to take her keys and followed her. According to the note, the bus driver was going to bring Grace up to the front of the bus. The final entry noted: *"don't want [the bus driver] to get into trouble."*
- 9.45 Mr. M did not have a recollection of this specific incident.
- 9.46 An undated note from Mrs. X to CW1 in 1998 referred to a telephone call between Mrs. X and the bus driver who stated that there was *"a lad on the bus who needs watching – he gets at the kids [and] his name is [name of individual]."*
- 9.47 A further undated note from Mrs. X to CW1 recorded that *"unfortunately [Grace] is wetting herself again. It appears there is someone on the bus who is 'getting at her'".*
- 9.48 CW1 recalled that there was somebody getting at Grace on the bus. She told the Commission that, in the ordinary course, if there was an issue raised in relation to transportation or the bus, the staff of Day Service Provider A spoke to either the taxi driver or the bus driver to get their opinions and observations. In this instance, she said, she dealt with it and then reported it informally to either Nurse N or Mr. M. CW1 did not remember whether this targeting of Grace by the particular individual was a recurring problem but she said that, when there was an incident, Mrs. X wrote a note about it.

- 9.49 There was no physical injury recorded to Grace with respect to the above date. However, it was an instance of the type of difficulties that could arise for Grace on the bus.

The year 1999

1st February, 1999

- 9.50 A note made on 1st February, 1999 recorded that it was Grace's first day back at Day Service Provider A after a long absence and that there were "*no marks*" on her body. The note recorded that Mrs. X telephoned about Grace's wetting and gum disease and that Grace attended for a full week.

20th September, 1999

- 9.51 There was one note with respect to a mark in 1999. A note prepared by CW11, a member of the care staff at Day Service Provider A, dated 20th September, 1999, stated that:

"[Grace] came in this a.m. and as usual headed straight for the toilet. [Grace] had a bath and staff noted an abrasion to her lower back. [Mrs. X] (foster parent) was notified about this and was okay about it. She expressed that she was more worried that [Grace] had absconded or been hurt."

Cause or explanation

- 9.52 Commenting on this note while giving evidence before the Commission, Mr. M said that Mrs. X's reaction, as recorded in the note, was no different to that of the parents of other service users, who were often relieved to hear that something was not wrong or that their child was not hurt.
- 9.53 Mr. M said that this note was in line with Day Service Provider A's practice of notifying the parents whenever staff noticed a mark, so that they would be in a position to account for themselves. The Commission considers that the note taken that Mrs. X "*was okay about it*" was consistent with his account of the practice.
- 9.54 There was no further issue or concern with respect to this note at the time.

9.55 Mrs. X did not recall the particular incident in her evidence to the Commission.

Finding

9.56 The nature of the abrasion observed on 20th September, 1999 was not recorded and was not recalled by the witnesses who gave evidence to the Commission. Apart from noting it, there appears to have been no further concern about it at the time. The Commission did not have any evidence, direct or circumstantial, that would support any finding that the abrasion arose as a result of any physical abuse of Grace. There was no evidence to support a finding that this abrasion occurred because of a physical assault of her by any person or persons.

The years 2000 to 2007

The year 2000

21st January, 2000

9.57 CW2 made a note that *“while [Grace] was being toileted, I noticed a small mark, which looked like a burn (cigarette) on the inside of her right thigh.”*

Cause or explanation

9.58 CW2 did not recall this entry, however, she recalled seeing a mark on the inside of Grace’s right thigh. She did not think that she had observed marks, other than scratches, on Grace’s right thigh at any time after 2000.

9.59 In her evidence to the Commission, CW2 said that she had never seen what was confirmed to be a burn mark on any person before and could not describe what a cigarette burn mark looked like at the time that she gave evidence to the Commission. It was apparent from what CW2 told the Commission that she made the note and described the mark as something *“which looked like a burn (cigarette)”* based on her opinion as to what the mark represented.

9.60 In a Garda statement which she made in 2012, CW2 had recalled the mark from memory as being red in colour and located *“on [Grace’s] upper leg towards her knee on the front”*. When giving her Garda statement, CW2 did not recall what she thought had caused this red mark.

- 9.61 A mark that was seen as a suspected cigarette burn was, by its nature, a suspicious mark and one that ought to have caused concern and further enquiry at the time. The evidence to the Commission, however, as to what occurred in this regard was unclear. CW2 was unable to recall what she did about this mark and could only assume that she went immediately to speak to her supervisor or manager at Day Service Provider A about it at the time, as was the “*practice*”. However, there was no co-signatory to this particular note and the Commission had no evidence of any follow-up or further discussion with respect to the entry at that stage. Mr. M gave evidence that notes of this kind would have been placed directly on Grace’s file.
- 9.62 Mr. M told the Commission that he never saw this mark on Grace and that he did not remember it. He could not remember CW2’s bringing it to his attention, but emphasised that that was not to say that CW2 was wrong in that she saw something. He did question, however, why there was no co-signatory to the note, particularly if it related to something so serious.
- 9.63 The Commission is satisfied that Mr. M would have considered a mark which was suspected to be cigarette burn mark as being a very serious matter and that it was likely to have been raised with Mrs. X if it had been brought to his attention. This was consistent with the evidence of regular contact between Day Service Provider A and Mrs. X on issues of marks or bruising when they arose. However, there was no evidence of follow-up with respect to this particular mark.
- 9.64 Mrs. X, in her evidence, did not remember having any contact from Day Service Provider A in relation to a mark on Grace which looked like a cigarette burn. She did not remember hearing anything about it at any stage.
- 9.65 It is of note that the mark itself did not cause any other further concern within Day Service Provider A as an injury after this date. There was no note or evidence of any treatment being required for the mark. There were no further entries or notes in Day Service Provider A’s records of any mark of the same variety or causing similar concern.
- 9.66 There was some confusion about the level of significance, if any, that had been attributed to the mark in Day Service Provider A. The evidence of CW1 was somewhat vague on this aspect. Her recollection was that there had been an incident with respect to Grace, not that there were incidents; that something had happened,

and that it was her job as part of the team to be vigilant. What she recalled, she said, was being told that Grace was being harmed or that she had been harmed and there was a suspicion of her being harmed. CW1 could not recall, however, what this incident was supposed to have been. In the course of her evidence, CW1 initially thought that she had been told of this mark in the early stages of her work in Day Service Provider A in 1997 and in the context of being told to be vigilant in looking for any marks on Grace when she was involved in her care. She said that she suspected that she had been told by Nurse N that it was a cigarette burn. In this regard, CW1 linked the drawing of her attention to the mark to what she had been told about checking for marks on Grace. However, in view of the fact that this particular mark was not recorded until January, 2000, three years after CW1 commenced work, CW1 readily acknowledged that there was an absolute possibility that she had mixed up her timelines. This was understandable, having regard to the length of time that had passed since her day-to-day involvement in Grace's care.

- 9.67 This particular mark was something that Mr. Smith identified at a later stage, in March, 2009, and it was a mark observed by Dr. O'Gorman, Forensic Examiner at that time at the Sexual Assault Treatment Unit ("SATU") in Waterford Regional Hospital as being a *"round healed mark"* on Grace's inner thigh. Mr. Smith surmised at the time that, although it was not possible to determine the cause of the mark, it *"could be a cigarette burn or healed sore or of other origin."* Grace's attendance at the SATU is reported upon in Chapter 4 of this Volume and in Chapter 14 of Volume 1.

Finding

- 9.68 The evidence received by the Commission with respect to this mark which was noted in January, 2000, was not sufficient to support a finding that it had, in fact, been caused by a cigarette burn. The evidence of CW2, the author of the note recording the mark, was too uncertain to place any reliance on her view that that was how it had occurred. This is not a criticism of CW2, who properly noted her view of the mark at the time. There was no other evidence that might have assisted the Commission as to how or where the mark might have occurred.
- 9.69 There was no investigation or enquiry made at the time as to how Grace might have come to have this mark. Its origins can, therefore, only be a matter of speculation at this stage. The Commission is not satisfied on the evidence considered above that

the mark in question had, in fact, been caused by a burn from a cigarette. Further, there was no evidence to support a finding that this arose because Grace had been physically assaulted or abused by any person or persons.

24th January, 2000

9.70 A note was made by CW2 on 24th January, 2000 concerning a scratch on Grace's neck. It stated: "[Grace] *went to bowling today and Funderland. She was in good form all day. Had mark on neck (back) like a scratch.*"

Cause or explanation

9.71 CW2 could not remember anything about this note. Mr. M did not either, but said that Day Service Provider A knew about these scratches. He recalled the staff seeing scratches on Grace at times, reiterating that she tended to scratch at her acne.

9.72 Mrs. X did not remember being contacted regarding this scratch on Grace's neck.

Finding

9.73 The evidence to the Commission did not identify the particular circumstances as to how Grace got this scratch mark. There was no evidence to suggest that this mark was one that was out of the ordinary for her, having regard to the evidence about her scratching, as reported above. There was no evidence to support a finding that it arose because of a physical assault of Grace by any person or persons.

25th January, 2000

9.74 CW2 made a note that "[Grace] *wasn't in good form today + kept banging her head off the wall. I brought her up to the shop where she got sweets but [she] still didn't cheer up. Her left eye seemed puffy and swollen.*"

Cause or explanation

9.75 CW2 told the Commission that Grace's "puffy" eye could have been the result of her banging her head. It could have occurred in Day Service Provider A or before she arrived on the bus; it was not clear. The primary concern, CW2 said, was the fact that Grace had an injury, not when or where the injury occurred.

- 9.76 In relation to this entry, while Mr. M did not recall it, he said that, if Grace had a puffy or swollen left eye as a result of head-butting, it would not have surprised him, adding that he had seen periorbital bruising on her before, when she had banged her head, due, he believed, to the fact that she was so “*fragile*”.
- 9.77 Mrs. X remembered Grace coming home with a “*bad eye*” but her evidence with respect to this entry (as well as another entry about a black eye that Grace had presented with, reported upon above) appeared to be conflated with an eye injury in 2008, which is discussed below.

Finding

- 9.78 The Commission is satisfied that the most likely cause of Grace’s puffy and swollen eye as noted on 25th January, 2000 was her banging her head in Day Service Provider A or on the bus. There was no evidence to support a finding that it arose because of a physical assault or abuse of Grace by any person or persons.

The year 2001

- 9.79 There were no notes or records of any physical injuries or any concern about physical injury to Grace in the course of 2001 contained in the documentation disclosed to the Commission by the HSE, or on behalf of the local voluntary association or Day Service Provider A.

The year 2002

- 9.80 There was one record made of marks to Grace in 2002.

5th December, 2002

- 9.81 A programme assistant in Day Service Provider A made a note stating that Grace had been pushed by one of the male service users. Grace was examined by CW2 who found a few scratches on her. Mrs. X was informed.

Cause or explanation

- 9.82 While CW2 could not recall the particular note, she gave evidence of Grace’s having exchanges with that service user. She said that there were a number of incidents

involving him and Grace and she remembered one incident when he tried to pull Grace around the kitchen in Day Service Provider A. CW2 said that the other service user “*targeted*” Grace (among others) because she was non-verbal and because she would not “*fight back*.”

9.83 CW2 said that, whereas in Day Service Provider A the staff would be able to anticipate this other service user’s behaviour, they had no control over it when he and Grace travelled on the bus.

9.84 Mrs. X remembered being told about this incident, and the service user’s name being mentioned, but she did not remember when it happened.

Finding

9.85 The Commission considers that the scratches referred to in the above note from December, 2002 were, in all likelihood, caused in connection with the reported incident of the male service user’s pushing Grace. The note reported the incident with the service user and that staff had found a few scratches on Grace in that context. There was no evidence to support a finding that these scratches occurred because of any other manner of physical assault or abuse of Grace by any person or persons.

The years 2003 to 2006

9.86 As reported in Chapter 3 of this Volume, Grace had substantial periods of absence from her day placement in Day Service Provider A over the period 2003 to 2006. However, she did also have periods of attendance and limited notes from that time are referred to in Chapter 6 of this Volume.

9.87 While noting that there were substantial periods of absences during this time, there were no specific notes or incidents disclosed to the Commission for consideration or evidence provided with respect to any marks, bruising or injuries to Grace over this time.

The year 2007

9.88 Ongoing issues concerning Grace’s travel on the bus were reflected in a note dated 26th February, 2007. This stated that:

" [Mrs. X] rang up to enquire how [Grace] got on. I told her she got on grand. [Mrs. X] explained how she is keeping the keys at home in an attempt to calm [Grace] down on the...bus. She explained to [Grace] that she will get the keys back when she gets home."

- 9.89 In a note made about Grace on 2nd March, 2007, CW2 recorded the following in the Service Users' Daily Report Book:

"Received a 'phone call from [Mrs. X] on Thursday afternoon. She is keeping [Grace] home today as she was bold on the bus both coming to [Day Service Provider A] and going home. So as a consequence she is keeping her home. She will ring [the bus driver] when [Grace] is coming back in."

- 9.90 Mrs. X remembered this conversation when she came to give evidence to the Commission. She recalled occasions when she had to keep Grace at home because she had been "bold" on the bus and she agreed that it happened often. The sort of behaviour Mrs. X referred to in this regard was Grace's "jumping around on the bus" and the "lads and everything at her". Mrs. X said that the bus driver could not control Grace on the bus. She said that she thought that the head-butting happened every day Grace was on the bus to Day Service Provider A.

23rd April, 2007

- 9.91 A note was made at Day Service Provider A on 23rd April, 2007 that Grace arrived at the day centre that morning with a "red right eye". The corresponding body chart contained a note which read: "[r]ight eye lid red on arrival into [Day Service Provider A]."

Cause or explanation

- 9.92 In his evidence, Mr. M did not remember Grace's return to Day Service Provider A on this occasion, after a period of absence, but he did recall her having redness to her eye. Mr. M said that it had probably been reported to Mrs. X who, "more than likely", would have said that the bus driver had told her about Grace's banging her head.

- 9.93 Mrs. X told the Commission that she could not remember any time when Grace left her in the morning to go to Day Service Provider A with a red right eye. She said that she also could not recall the staff of Day Service Provider A contacting her about such a matter.

Finding

- 9.94 It was not clear from the evidence at the Commission as to whether this red eye was an injury or something that arose from some other reason or condition. There was no follow-up about it evident in the documentation disclosed to the Commission. Nor was there any evidence that it was in the nature of an injury of bruising that became a black eye.
- 9.95 The evidence to the Commission did not disclose the particular circumstances as to how or why Grace's eye became red on 23rd April, 2007. There were no further entries with respect to this and no follow-up as to whether this was an injury or whether she had a red eye for another reason, such as infection. The Commission considers, having regard to the evidence, that Grace's banging her head is likely to have accounted for this presentation. The Commission is not satisfied that this cause can be reasonably excluded in the circumstances. There was no evidence to ground a finding that this redness to Grace's eye arose because she had been subject to a physical assault or abuse by any person or persons.

1st/ 2nd July, 2007

- 9.96 On either 1st or 2nd July, 2007, a note recorded that Mrs. X rang Day Service Provider A in the afternoon to enquire if anything had happened to Grace's eye that day as she had noticed it was "*weeping*". The note recorded that "[n]othing happened in [Day Service Provider A]" and that Grace was in good form otherwise.

Cause or explanation

- 9.97 Mr. M said that this type of interaction with Mrs. X was typical, in that if Mrs. X noticed an injury to Grace, she would telephone Day Service Provider A to enquire about it.
- 9.98 Mrs. X could not recall this conversation when she gave evidence before the Commission.

Finding

9.99 There was no evidence to support a finding that this “weeping” of Grace’s eye arose because she had been physically assaulted or abused by any person or persons.

The year 2008

9.100 As reported above, in her first conversation with Mr. Smith in June, 2008, Ms D, the new Manager of Day Service Provider A, was asked to take a note of any mark on Grace of any description and convey that to him. It appears from the evidence, considered below, that this was duly done.

22nd February, 2008

9.101 A note made by CW6 recorded that Grace had a “bruised” left eye.

Cause or explanation

9.102 CW6, who made the note, recalled Grace’s banging her head generally but did not recall specific incidents or times when this occurred, including on 22nd February, 2008. CW6 did recollect an occasion when Grace had a yellow bruised eye, although she could not say whether it arose from this incident.

9.103 There was no further evidence available to the Commission about this note or its surrounding circumstances.

9.104 Mrs. X did not recall being notified by Day Service Provider A of this particular entry.

Finding

9.105 The evidence to the Commission did not identify the particular circumstances as to how or where this bruised eye had been sustained. The evidence was not such as to rule out the reasonable possibility that this injury had been sustained accidentally by Grace. While her presentation with a bruised left eye was concerning, there was no evidence to support a finding of fact that it arose because anyone had physically assaulted or abused her. Having regard to the evidence with respect to Grace’s behaviour of head-butting, the Commission cannot rule out that she sustained this bruise by such self-injurious behaviour.

26th May, 2008

9.106 It was noted by staff of Day Service Provider A on 26th May, 2008 that “[Grace] *has a scratch on her hip*”. Also recorded in the note was the fact that she was absent from Day Service Provider A on 27th and 29th May, 2008.

Cause or explanation

9.107 There was no further evidence about the nature of this scratch or of any further follow-up in respect of this injury.

Finding

9.108 There was no evidence to support a finding that this scratch arose because Grace had been physically assaulted by any person or persons.

18th June to 20th June, 2008

9.109 A note, completed by a programme assistant on 18th June, 2008 and co-signed by Ms D, recorded that “*when toileting [Grace] this morning I noticed four separate red marks on [her] spine*”.

9.110 On the following day, 19th June, 2008, Ms D made a further entry, seemingly related to the same marks, recording that “[Grace] *was observed to have four ? pressure marks on her spine. Body chart completed.*” A further note, dated 20th June, 2008, recorded that a telephone call was received from Mrs. X who said that Grace had returned home “*wet*” on both Thursday and Friday and that she did not want her to fall back into “*old routines*”. Mrs. X was recorded as also asking if Grace was happy in Day Service Provider A.

9.111 On 20th June, 2008, a further note was made that Grace had “*three scratches*” on her back, with a corresponding body chart completed by Ms D which read: “[r]ed marks *observed on back. Skin marked not broken.*”

9.112 A note on Grace’s file dated 25th June, 2008 made by Mr. Smith of a conversation that he had with Ms D stated: “[I]ast week [Grace] *appeared to have sores on her spine. These were red marks and not bruises. I asked if these marks were more like*

friction burns, and [Ms D] said that they were. She did not know the reason and she had not discussed this with Mrs. X". Mr. Smith noted that Ms D did not think that it was worth involving a doctor as the red marks had disappeared and the scratches were of "indeterminate origin". This exchange between Mr. Smith and Ms D is reported on in Chapter 5 of Volume 1.

- 9.113 In terms of Mr. Smith's note above, Ms D did not recollect this conversation with Mr. Smith and could not recollect saying that the marks were friction burns or that she thought that they were friction burns. She told the Commission, however, that that did not mean that she did not say that. However, when asked if she viewed the marks as friction marks at the time, Ms D said that *"I can say with some certainty that I didn't. What I had documented was that they were pressure marks. I didn't describe them myself as being friction marks."*

Cause or explanation

- 9.114 Ms D explained that Grace very often presented with marks that were not *"concerning"*, saying that the staff of Day Service Provider A documented them and reviewed them if there was considerable concern. Ms D thought that, on that day, the four marks on the base of Grace's spine might possibly have been caused by the incontinence wear that she used at night-time. She said that Grace had rashes, which Mrs. X attributed to her use of incontinence wear.

- 9.115 Ms D did not recall speaking about these marks to Mrs. X. She had no reason to doubt what Mrs. X had said about the marks and, as far as Ms D was concerned, they were not concerning marks. She said that if she had had concern that they were the result of a non-accidental injury, they would have reported straightaway to Mr. Smith.

Findings

- 9.116 The Commission is satisfied that Ms D did not view the marks to Grace's lower spine as *"friction marks"*. Rather, she considered that they were *"pressure marks."*
- 9.117 The Commission also heard evidence from a number of staff members at Day Service Provider A and from Mrs. X that Grace suffered from rashes associated with her use of incontinence wear during the night.

9.118 The Commission accepts Ms D's evidence that she would have reported this to Mr Smith, had she had a concern that the marks were caused by a non-accidental injury.

9.119 The Commission considers that the likelihood is that these marks, recorded in the notes of 18th, 19th and 20th June, 2008, were caused by irritation and/or associated scratching related to the incontinence wear that Grace used at night-time. They may also have been caused by Grace's scratching, unrelated to the presence of incontinence wear. There was no evidence to support a finding that the marks arose because she had been physically assaulted or abused by any person or persons.

24th June, 2008

9.120 Ms D made a note of several scratches on Grace's lower back.

9.121 Mrs. X did not recall being contacted by Day Service Provider A in relation to those marks.

Cause or explanation

9.122 Ms D's evidence, again, was that she was not overly concerned about these marks and she said that Grace sometimes had dry skin.

9.123 There is no indication that these marks were raised with Mrs. X. Grace suffered from incontinence and was using incontinence wear around this time. This was a regular issue for Grace.

Finding

9.124 These scratches, observed on 24th June, 2008 may have been the same scratches recorded by the staff of Day Service Provider A on 18th, 19th and 20th, June 2008. Having regard to the records of Day Service Provider A disclosed to the Commission and to the evidence of staff there and of Mrs. X, there was nothing particularly out of the ordinary in Grace's presenting with scratches of this nature. There was no evidence to support a finding that they arose because of a physical assault of her by any person or persons.

1st July, 2008

9.125 It was noted that when CW6 was helping Grace in the bathroom, she observed a red mark just above her bottom, with the skin broken. CW6 noted that *Sudocrem* antiseptic cream appeared to have been applied to the mark.

9.126 CW6 recalled seeing this mark. She said that the skin was broken and that the *Sudocrem* was dried into it. CW6 said that if a mark was observed and needed to be recorded, it would have been brought to the manager of Day Service Provider A's attention.

9.127 Mrs. X told the Commission that the red mark must have caused by the incontinence wear that Grace used as, she said, it was located in the region where the incontinence wear was in place. Mrs. X told the Commission that she always put *Sudocrem* on Grace. She did not remember being contacted by Day Service Provider A in relation to this matter.

Cause or explanation

9.128 There was nothing of concern that struck Ms D in relation to this entry. She told the Commission that it did not appear to her to be a non-accidental injury at the time or when she gave evidence to the Commission.

9.129 Ms D told the Commission that, at that time, because concerns had been raised about Grace, they were being more diligent in their recording of any marks or injuries to her.

Finding

9.130 The Commission is not satisfied that this mark evidenced any physical abuse of Grace. There was no evidence to support a finding that it arose because she had been physically assaulted or abused by any person or persons.

15th July, 2008

9.131 Ms D made a note of a scratch on the right side of Grace's face.

9.132 Mrs. X did not recall being contacted by Day Service Provider A in relation to this particular matter. In reference to that mark, however, Mrs. X told the Commission that she believed that it would have been caused by Grace's plastic keys.

Cause or explanation

9.133 There was no specific cause identified in the evidence before the Commission for this scratch to Grace's face. Ms D gave evidence that it did not strike her as unusual at the time, since Grace presented with scratches from time to time. Generally, she said, such scratches were not a cause for concern. Ms D told the Commission that, at the time of giving her evidence, Grace still presented with scratches in the residential setting, almost 10 years after her removal from her home with Mrs. X.

Finding

9.134 This mark in itself did not indicate any physical abuse of Grace. There was no evidence to support a finding that it arose because she had been physically assaulted or abused by any person or persons.

20th August, 2008

9.135 On Wednesday, 20th August, 2008, bruising and marks were observed in the area around Grace's right eye. Ms D made a note of her observations in the Service Users' Daily Report Book, recording that the area in question "*appeared swollen and had two small broken areas of skin*". This observation resulted in Grace's removal to Waterford Regional Hospital for medical examination. A detailed account of the sequence of events that followed the taking of this note is reported in Chapter 7 of Volume 1 and in Volume 4 (generally referred to as the "Garda Volume").

9.136 As referred to above, there was an arrangement in place by this time whereby Mr. Smith was to be contacted by Day Service Provider A about any concerns of presentation of non-accidental injury to Grace. After being alerted of the marks by Ms D, Mr. Smith arrived at Day Service Provider A at approximately 2 p.m. and, having observed the injury, wanted to have Grace examined by a doctor at Waterford Regional Hospital. He subsequently spoke about that to Ms Margaret Browne, Coordinator of Disability Services, Waterford Community Care, HSE, who agreed with that course of action. In his notes, Mr. Smith described Grace as appearing to

have a *“yellow bruise under her right eye”* which was fading, as well as *“two small scabs on the edge of the bruise.”*

9.137 Mr. Smith told the Commission that, while he considered the injury to Grace to be suggestive of non-accidental injury, he was unsure of the legal basis of any intervention on their part, and that he contacted An Garda Síochána to see if the HSE was allowed to bring her for medical examination and treatment. Mr. Smith’s contact with members of An Garda Síochána is more fully reported on in the Garda Volume.

9.138 The medical records from Waterford Regional Hospital’s Emergency Department recorded that Grace presented there at 3.50 p.m. with *“bruising noticed around [right] eye by day care staff”*. The part of the records completed by the nurse who first saw her also recorded: *“Some irregularities in history from carers ?NAI [i.e. query as to non-accidental injury].”* The notes prepared by the doctor who examined Grace at 4.25 p.m. recorded: *“Alleged difficulties + other complaints re this household. *? Story from foster care family to Day care staff was not usual protocol”*. With regard to the bruising to Grace’s eye area, the doctor’s notes recorded: *“[Right] infra orbital bruising [approximately] 5-7 days old with 2 small scabs/crusts inferolaterally.”* The doctor also made notes regarding what appeared to be an old injury to Grace’s little finger on her left hand: *“[Left] Little finger- deformity- ? old [fracture]”*.

Cause or explanation

9.139 In her evidence, Ms D said that this injury was a *“concern”* to her because of its particular location and its resemblance to a black eye, with faded bruising. She told Ms B, a newly appointed social worker with the local voluntary association at this time, about it. Ms B’s note of the injury described it as *“yellow - brown bruising under right eye on cheek bone with two broken skin marks on bruise with scabs”*, which Ms B noted appeared to be healing.

9.140 Ms B and Ms D both said during their evidence to the Commission that this particular injury raised a question for them as to whether it was non-accidental. Ms D told the Commission that Grace’s injury was *“something that would strike me then and now as not being easily explained if somebody presents with swelling and bruising around their eye”*. Ms B’s note of the injury continued: *“? Cause ? noted previously. Checked daily report book - no record of bruising. [Grace] has full attendance this week.”*

- 9.141 Ms D made enquiries with Day Service Provider A's bus driver, Mr. H, who thought that Grace might have banged her head on the bus window the previous Thursday (14th August, 2008), though in evidence she said that the bus driver was "*vague about it.*" Ms D said during her evidence that she had previously agreed with Mr. H that he would report any issues with Grace on the bus and did not know why he had not reported this issue to her. Mr. Smith's note indicated that he and Ms D discussed whether the injury would be "*consistent with a black eye*". During his evidence, Mr. Smith said that, from a "*social worker point of view*", he would have preferred if he, rather than Ms D, had spoken to the bus driver initially.
- 9.142 Ms D also contacted Mrs. X and asked her if she knew what had caused the injury to Grace. Mrs. X told her that she did not, but she said that she had noticed it the previous Friday (15th August, 2008), when Grace returned home from Day Service Provider A, and suggested to Ms D that it had happened on the bus, as Grace sometimes banged her head when travelling.⁸ Mrs. X also told Ms D that she had noticed the injury again the previous day, *i.e.* 19th August, 2008. The notes recorded that Mrs. X said that it had then appeared worse and that she had put "*powder*" on it.
- 9.143 Mr. M told the Commission that he recalled seeing the injury on the previous Tuesday (19th August, 2008) and Ms D told Mr. Smith a few days later, on 21st August, 2008, that "[Mr. M] *had seen it on Tuesday and was surprised that had no one else had.*"
- 9.144 Grace was then taken to Waterford Regional Hospital by Mr. Smith and Ms B and was seen quickly. Ms B told the Commission that Mr. Smith dealt with the doctor on their arrival at the hospital and gave him some background information to which she was not privy. She said that there were two conversations, one before and one after Grace was x-rayed.
- 9.145 Mr. Smith said that he would have outlined Grace's history to the doctor and that it must have been clear to the doctor that she lacked capacity. He said that he might well have told the doctor about the background of the concerns that they had about her in non-specific terms. He thought that the background information and history outlined by him had clearly alarmed the doctor and that this, allied with Grace's presentation, prompted the doctor to offer to find a place for her instead of letting her

⁸ In a letter which Ms Browne received from Mrs. X on 16th September, 2008, Mrs. X attributed the bruising to Grace's having banged her head on the bus.

go back to Mrs. X's. However, as reported in Chapter 7 of Volume 1, this was not an option that was pursued.

- 9.146 As noted above, when Grace was examined in hospital, the bruising was recorded in the medical notes as *"5-7 days old with 2 small ?scabs/crusts"*. This timeframe was consistent with the possibility that it had been sustained the previous Thursday, the date referred to by the bus driver, as reported by Ms D.
- 9.147 Grace's face was x-rayed and the x-ray showed that there was no fracture. The hospital doctor said that she had some kind of injury to her face but could not say how it had been caused. Ms B had also drawn the doctor's attention to the fact that Grace had a bent (left) little finger. This was also x-rayed and, after discussing it with the consultant, the doctor said that he believed it to be an old fracture which had never set properly.
- 9.148 A report prepared by the Waterford Regional Hospital Radiology Department following the x-ray of Grace's facial bones and left little finger on that date confirmed no finding of a fracture with respect to her face. The finding regarding the little finger was as follows: *"No new fracture identified. The appearances could be due to old fracture"*.
- 9.149 Ms B said that Grace was *"very restless"* in the hospital that day and that she spent a lot of time walking around with her while Mr. Smith was waiting and talking with doctors or making telephone calls. Mr. Smith's note of events also recorded that, on several occasions, Grace climbed onto trolley beds and tried to pull Ms B in with her. She also grabbed a female patient and touched her breasts, and he and Ms B had to pull her away. Mr. Smith told the Commission that he did not have any impression of what had caused that, saying that Grace was a *"very active young person"*, always ready to move and not really able to sit still. Ms B did not give any evidence about Grace's grabbing a patient. Speaking of the note which recorded that Grace tried to pull her onto the bed, she said that if Grace was anxious, she would *"grab or pinch under your arm and pull on you."* She said that her behaviour in trying to pull her was an extension of that. She did not read it as denoting anything sexual.

Grace's return to Mrs. X's house

9.150 Having finished up at the hospital, Mr. Smith and Ms B brought Grace back to Mrs. X's house, arriving there, according to Ms B, at approximately 7.30 p.m. Mr. Smith, Ms B, and Mrs. X spoke together for approximately ten minutes. Mr. Smith's note recorded that he told Mrs. X how Grace had presented with a *"black eye and two small scabs in the same area"*. Insofar as the bruise was concerned, his note stated that Mrs. X told them that she had noticed the bruise *"getting worse"* that morning and that she had put antiseptic powder and cream on it. Regarding the scabs that had been observed, Mr. Smith recorded Mrs. X as saying that Grace had no marks on her eyes when she left to go to Day Service Provider A that morning and that they must have happened there. Mr. Smith's note stated that he said that the scabs were old, which Mrs. X said was *"impossible."* According to Mr. Smith's note, Mrs. X recounted having spoken to Grace's bus driver that morning, who told her that she had banged her head on the bus the previous Thursday, something she told them she had not known about. During her evidence, Ms B said that she asked Mrs. X that evening why she would have put antiseptic powder on a bruise, describing the whole conversation with Mrs. X as a *"very confusing dialogue."*

9.151 On this aspect, Ms B's note stated:

"[Social workers] spoke with [Mrs. X]:

Advised that doctor examined face and X-ray taken.

[Mrs. X] advised that she spoke with [Mr. H] the bus driver and said [Grace] 'got a crack on Thursday'. [Mrs. X] stated that she put cream and powder on [Grace's] face that morning (gesturing to the left side of her face)

[Social worker queried] what type of powder or cream - [Mrs. X] replied antiseptic powder.

[Social worker queried] the broken skin/cuts to [Grace's] face.

[Mrs. X] *stated that there were no cuts to [Grace's] face that morning and they must have occurred in [Day Service Provider A].*

[Social worker] *advised [Mrs. X] that the broken skin had formed scabs on them and they were not fresh cuts when they were observed this AM, which was confirmed by the doctor in A&E. [Mr. Smith queried] origin of damage to [Grace's] finger on left hand. [Mrs. X] replied that it has 'always' been there. Advised that x-rays would be viewed and reported on by radiologist. Also advised [Mrs. X] that [Grace] needed no treatment and that her cheekbone did not appear to be sore as a result of the injury."*

- 9.152 Regarding Mrs. X's account of how Grace might have come to have the bruising to her eye and the marks, Ms B gave the following evidence:

"in the 'phone call versus when we spoke with her later on that evening that there was some disparity and...there was a suggestion that she had seen it the previous Friday, but it was gone over the weekend and appeared again on the Tuesday and that the abrasions observed hadn't been there that morning when she left, they must have happened in [Day Service Provider A]. But they were healing, you know, they weren't fresh cuts. But then she said she had applied a powder and when I asked what type of powder, she said an antiseptic powder."

- 9.153 According to Mr. Smith's note, when he told Mrs. X about the fracture to Grace's finger, she told him that that pre-dated her placement with her in 1989 and did not express concern that it was *"poorly healed."* In evidence, Mr. Smith said that there was no reaction from Mrs. X to that news from the hospital. He said: *"I was just asking [Mrs. X] was she aware of it, had she noticed this before and I think [she] said that she hadn't or that she had or that it wasn't anything, that she wasn't fussed about it"*.

Mrs. X's recollection of events

- 9.154 Mrs. X's memory and her evidence on the events of this day were very confused. She told the Commission that she thought that Grace was taken to hospital only

once, namely to the SATU in Waterford Regional Hospital. She could not remember a hospital visit relating to an injury to her eye. It was evident that she was conflating this hospital visit with one which took place in March, 2009, and which is reported upon below.⁹

- 9.155 In her initial evidence on the events of this day, Mrs. X was asked if she remembered any incident around mid-August, 2008 when Grace had a bad eye. She said that Grace had a “*bad*” eye, but that it was red as distinct from black. Mrs. X told the Commission that she did not know how that happened. Her memory was that, when Grace came home from Day Service Provider A, she bathed her and put cream on it, and she thought that it had sorted itself out. Mrs. X had no memory, when giving her evidence, of the particular date (the previous Thursday) on which, according to the bus driver, Grace might have banged her head on the bus.
- 9.156 Addressing Mr. Smith’s note of Ms D’s telephone call to her about the injury at the Commission, Mrs. X said that she remembered Ms D’s ringing her around 4.00 p.m. to tell her that Grace would not be home on the bus as she noticed she had “*spots*”. Mrs. X told the Commission that she asked Ms. D how Grace got the spots, to which Ms D replied that she did not know, but that Mrs. X was not to worry and that she would bring her back to her. Mrs. X said that Ms D did not mention Grace’s eye to her during that conversation. At the same time, however, Mrs. X said that she told Ms D that she had noticed the injury to Grace’s eye on the previous Friday and that she had put powder on it on the Tuesday.
- 9.157 Mrs. X said that she did not remember a conversation with Mr. Smith in relation to the injury to Grace’s eye or applying treatment to it.
- 9.158 Mrs. X said that she also did not remember hearing about Grace’s hand being x-rayed at the hospital and an old injury found on her finger. In her evidence to the Commission, she said that she never saw that injury over the years Grace was living with her. She said that Mr. Smith must have told her about the injury to Grace’s finger, but she could not remember when that was. However, as noted above, Ms B’s record of the conversation with Mrs. X recorded that she told them that the injury had “*always*” been there.

⁹ As reported in Volume 1, Grace was taken to hospital again early in the evening of 27th March, 2009 and was returned to Mrs. X by Mr. Smith, Ms D, and Ms B in or around midnight. This hospital visit is also referred to in Chapter 4 of this Volume.

9.159 The Commission was able to place only a limited weight on Mrs. X's evidence of the events of this particular day, given the confusion on her part, referred to above.

"Inconsistencies" regarding injuries to Grace

9.160 According to Mr. Smith's note, he and Ms B felt that there were "*inconsistencies*" in relation to the matter of Grace's injury, observing, for instance, that Mrs. X had not brought it to anyone's attention, despite previously claiming that she could not attend Day Service Provider A due to possible injuries on the bus. Another inconsistency was that, according to his note, "*no injuries were known previously*", yet when one occurred, Mrs. X did not tell anyone about it. However, Mr. Smith said in evidence that he was "*not really clear*" what he was saying when he recorded in his note that no injuries had been known previously (as reported on above, there had been various marks and bruises to Grace previously). He thought that the remainder of the sentence related to the current injury. His note also recorded an alleged inconsistency regarding the day on which Mrs. X put powder on the injury. Ms D told him that Mrs. X said that she had applied it on the Tuesday, but Mr. Smith recalled that Mrs. X told him that she did that on Wednesday.

9.161 Ms B told the Commission that, after they left Mrs. X's house, she and Mr. Smith discussed concerns that they had in Day Service Provider A, as well as topics such as "*general neglect*", "*physical abuse*", and "*financial abuse*". Insofar as Grace's injury was concerned, Ms B recalled being of the view that it had, in all likelihood, occurred in Mrs. X's house, instancing the discussions with Mrs. X and the "*inconsistency in the explanation*", as well as some preliminary enquiries which had been made by Ms D.

9.162 When giving evidence to the Commission on a later date, in connection with his dealings with An Garda Síochána, Mr. Smith told the Commission that he had a concern about what he considered to be an inconsistent explanation for this bruising to Grace's eye. In this regard, he said, "*but I didn't think it was something, I never really thought that the Gardaí would take that on as a crime*". Mr Smith said that the issue was "*more a concern of neglect and allowing an injury like that to have occurred and not being clear in the exchanges between [Day Service Provider A] and [Mrs. X] as to what had occurred*".

Findings

- 9.163 The explanation offered for the injury to Grace's eye in the evidence of what the bus driver told Ms D was ultimately not contradicted by the evidence or surrounding circumstances with respect to this particular event. While it was reported that the bus driver could not be definite, he had referred specifically to the previous Thursday and he thought that Grace might have banged her head on the bus on that day. It is of note that Ms D's first port of call, on noticing the bruise, was to the bus driver to check if Grace could have sustained this injury on the bus. The Commission is satisfied on the evidence heard during its investigations that this was because of the history, well known in Day Service Provider A, about the problems which Grace sometimes had on the bus and because of her behaviour of head-butting. There was no evidence of any follow up conversation with the bus driver on this occasion.
- 9.164 On the evidence to the Commission, Mrs. X had not been told of the bus driver's conversation with Ms D before she told Mr. Smith and Ms B that the bus driver had told her (as Ms B recorded it) that Grace "*got a crack on Thursday*".
- 9.165 With respect to inconsistencies in Mrs. X's responses between her conversations with Ms D, on the one hand, and with Mr. Smith and Ms B, on the other, when they brought Grace home on the evening of 20th August, 2008, the Commission is not satisfied that they were such as to support a view that this was an injury that Grace had sustained as a result of physical assault or abuse.
- 9.166 With respect to the observation that there was an inconsistency because Mrs. X had not brought the bruise to anyone's attention, despite her "*previous claims*" that Grace could not attend Day Service Provider A due to possible injuries on the bus, the Commission cannot be satisfied that this constitutes evidence that undermines the position as reported by the bus driver. On this occasion, a possible cause for the bruising was not identified until both Ms D and then Mrs. X spoke to the bus driver on 20th August, 2008.
- 9.167 Mrs. X's account of not seeing the injury over the weekend and noticing it again on the Tuesday, and the issue as to whether she put powder on it, whether there was a point in doing so, or whether she said that she had done so on the Tuesday or the Wednesday, was jumbled and confused. However, the Commission is not satisfied that this, of itself, evidenced that the bruising had not been sustained the previous

Thursday. This timeline was consistent with the medical assessment, which dated the bruising at between five to seven days old.

9.168 This injury had not been picked up and noted in Day Service Provider A until Wednesday 20th August, 2008 although, in accordance with the records, Grace had full attendance that week. On the previous day, 19th August, 2008, her general excitability and hyperactive behaviour was noted in an incident recorded on that day. The fact of the bruising and two small scabs was not recorded on the Tuesday. In this regard, Ms D told Mr. Smith on 21st August, 2008 that “[Mr. M] *had seen it on Tuesday and was surprised that no one else had.*” As Ms D noted on 20th August, 2008, it was she who noticed the discolouration under Grace’s right eye when she was sitting in front of her in her office during the morning.

9.169 The evidence does not permit the Commission to establish where and how Grace sustained this bruising. However, having regard to the evidence that this was sustained on the bus on the previous Thursday, 14th August, 2008, that possibility cannot be ruled out. The Commission is not satisfied that the evidence was such as to establish that this injury resulted from Grace’s having been subjected to physical abuse in the circumstances.

9.170 The evidence with regard to Grace’s little finger established that this was an old injury. That it pre-dated her placement with Family X could not be ruled out. There was no evidence as to how that injury had occurred and no evidence upon which the Commission could conclude that it arose as a result of physical abuse.

31st August, 2008

9.171 Grace was noted to have two small scratches on her chest and a scratch on her left side of her back.

9.172 The Commission had no further evidence with respect to this note. There was no follow-up or indication that these scratches were a matter of particular concern. They were noted in the same way as every mark on Grace was to be recorded.

9.173 Neither CW2 nor CW6, who were assigned as key workers to Grace at particular times during the period the subject of this Volume, had any recollection of these

marks. Mrs. X could not recall these scratches, nor could she recall being contacted by Day Service Provider A about them.

- 9.174 By their very nature, and having regard to the realities of Grace's day-to-day life and activities, the Commission observes that not every scratch or mark on her during the period the subject of this Chapter/ Volume can be tracked and explained.

Finding

- 9.175 The evidence to the Commission did not identify the particular circumstances as to how or where these scratches had been sustained. The Commission had, however, ample evidence of Grace's sustaining scratches in the ordinary course of her day-to-day life. These were unremarkable, insofar as they were not unlike the many other scratches that she presented with from time to time, as outlined above. There was no evidence to support a finding that these scratches arose because of a physical assault or physical abuse of Grace by any person or persons.

11th September, 2008

- 9.176 CW6 made a note that "[t]here are little red bumps on the back of [Grace's] neck just under the hairline."

Cause or explanation

- 9.177 When asked about these bumps during her evidence to the Commission, CW6 did not remember anything about them.
- 9.178 Mrs. X did not recall little red bumps ever being brought to her attention by the staff of Day Service Provider A and did not know how these had come about, adding that Grace "*always had spots.*"
- 9.179 Commenting on this entry, Ms D said that Grace had and continued to have spots on her skin from time to time.

Finding

9.180 The Commission is satisfied that these little red bumps did not raise any concern at the time they were observed that they were the result of an injury or that they were suggestive of physical abuse of Grace.

22nd September, 2008

9.181 CW6 recorded that Grace had *“a small spot on the right side of her head”*. Her note went on to say that it appeared as though Grace had *“scratched this spot as there was dry blood surrounding it. This blood [was] wiped off easily”*.

Cause or explanation

9.182 CW6 had no memory of that particular spot.

9.183 Mrs. X told the Commission that she was not contacted about this spot.

Finding

9.184 The Commission is satisfied that this spot did not raise concern that it was a non-accidental injury or that it was suggestive of any physical abuse of Grace.

9th October, 2008

9.185 CW6 and CW2 signed a body chart on 9th October, 2008 noting a *“bruise”* to Grace’s *“right knee”*.

Cause or explanation

9.186 There was no evidence that Mrs. X was notified at the time about an injury to Grace’s right knee.

9.187 There was no other evidence available to the Commission, from the staff of Day Service Provider A or any other persons, regarding this bruise. It does not appear to have caused any further concern. Nor was there any enquiry or further exploration as to how or where Grace might have got it. There was no indication that a bruise on her right knee was a feature that was overly concerning or surprising.

Finding

9.188 Having regard to the evidence concerning Grace's day-to-day life and her activities, the Commission is not satisfied that a bruise to her right knee was indicative or suggestive of her having suffered physical abuse. That Grace sustained this accidentally could not be reasonably ruled out. There was no evidence to support a finding that this arose because she had been physically assaulted or abused by any person or persons.

15th October, 2008

9.189 CW6 noted that Grace "*has a small scratch on the left side of her lower back*". This was recorded in a body chart and signed by her and a co-worker.

Cause or explanation

9.190 In evidence, CW6 had no recollection of this scratch. There was no follow-up or further concern recorded.

9.191 In her evidence to the Commission, Mrs. X surmised that a mark such as this might have been caused by the incontinence wear that Grace used at night-time.

Finding

9.192 The Commission does not consider that this scratch pointed to or supported any concern that Grace was subjected to physical abuse. There was no evidence to support a finding that this arose because she had been physically assaulted or abused by any person or persons.

21st October, 2008

9.193 CW6 and CW7 made a note of two large spots on Grace's face which appeared to have cream on them.

Cause or explanation

9.194 In her evidence to the Commission, CW7 did not recall this being a matter of any significant concern at the time and thought that the spots might have been boils, possibly due to Grace's acne.

9.195 In giving evidence to the Commission, Mrs. X spoke about Grace's having spots on her skin and she said that she used *Sudocrem* antiseptic cream to treat them. She said that it was likely that she would have put *Sudocrem* on her spots.

9.196 As noted above, these skin problems continued for a long time after Grace was moved from Mrs. X's care into residential care.

Finding

9.197 This note does raise any concern that Grace was subjected to physical abuse.

31st October, 2008

9.198 On 31st October, 2008, CW6 observed two scratches on Grace's neck. On the same date, it was recorded that she had had her hair pulled by another service user.

9.199 There was no further evidence available concerning the above entry. There was no follow-up and no further concern about these two scratches.

Finding

9.200 The Commission does not consider that these scratches pointed to or supported any concern that Grace was subjected to physical abuse. The Commission had ample evidence of occasions on which Grace scratched herself, including with her plastic keys. There was no evidence to support a finding that these scratches arose because of a physical assault or abuse of her by any person or persons, as distinct from their being the result of an accidental injury.

The year 2009

10th February, 2009

9.201 On 10th February, 2009, CW8, CW2, and Ms D signed a body chart which noted that Grace had an *“old scratch on right hand side of forehead”*.

9.202 Neither CW8 nor CW2 had a recollection of this by the time they gave their evidence at the Commission.

9.203 Ms D also did not have a recollection of this scratch. She told the Commission that the very fact of this scratch having been brought to her attention and her signing the body chart would have provided staff with reassurance that they had reported it.

9.204 Mrs. X did not recall this scratch at the Commission, nor did she have any recollection of being contacted by Day Service Provider A about it.

Findings

9.205 There was no evidence to the Commission that this *“old”* scratch was of any particular concern. It appears to have been noted because of the practice that any kind of a mark on Grace was to be recorded.

9.206 The Commission is not satisfied that this scratch raised or raises any concern that Grace had been subjected to physical abuse. There was no evidence to support a finding that this arose because she had been physically assaulted or abused by any person or persons.

11th February, 2009

9.207 CW7 recorded that Grace *“stayed in this morning with [CW12, who was a programme assistant in Day Service Provider A]. She appeared to be quite excited and agitated and did not take part in the activity of arts and crafts. [She was] [i]ncontinent of urine once during the morning. [CW8] (care staff) noticed red marks (rash like) on [Grace’s] thighs, see body chart completed. In the afternoon [Grace]*

stayed in the [day centre] again, similar behaviour, very restless and dragging and pulling out of staff.”

- 9.208 A corresponding body chart of the same date signed by CW8 and Ms D recorded: *“red rash on both upper thighs of left and right legs on the front”*. A separate entry for that date read: *“New small bruise over left hip.”*

Cause or explanation

- 9.209 Neither CW8 nor Ms D had a recollection of this specific entry at the Commission. CW7, who had only started working at Day Service Provider A in February, 2008, said that she was only getting to know the service users by this time and that she did not recall much information about Grace from that time.

- 9.210 With respect to *“dragging and pulling out of staff”*, CW7 said that, as far as she could recall, that became a part of Grace’s behaviour later on. She could not recall specifically when this escalation occurred, but she said that there was an increase in those behaviours after she moved into residential care. Grace’s presentation after she was moved on 17th July, 2009 is reported in Chapter 4 of this Volume.

- 9.211 At the Commission, Mrs. X did not recall this specific incident of a red rash on both of Grace’s upper thighs, but she said that, if it was a rash, it was caused by the incontinence wear that she used at night-time. She also could not recall being contacted by Day Service Provider A in relation to a small bruise on Grace’s left hip. There was no evidence that she was contacted and asked about the bruise.

Finding

- 9.212 The Commission is satisfied, on the evidence, that Grace suffered rashes from time to time, this being an issue reported upon in Chapter 3 of this Volume. With regard to the bruise on her left hip, the Commission cannot establish precisely how this might have occurred.

- 9.213 The evidence to the Commission did not identify the particular circumstances in which Grace sustained that bruise. There was also no evidence that would have supported a conclusion that its presence indicated that it arose because she had been physically abused.

9.214 There was no other evidence about the rashes noted on this occasion which suggested that they did not arise in similar circumstances as other rashes or redness associated with Grace's toileting issues and skin condition. There was no evidence to support a finding that these marks arose because of a physical assault or abuse of Grace by any person or persons.

18th February, 2009

9.215 A body chart dated 18th February, 2009 noted "*18/02/09: bruise on upper right thigh*".

9.216 By way of background regarding Grace's behaviour on that day, on 18th February, 2009, CW7 noted that "[Grace was] *quite agitated today. Came swimming this morning with myself and [CW8]; refused to leave her swimming togs on and tried going into the pool side with nothing on. As a result we had to get [Grace] dressed and leave her on the bus with [the bus driver] where she sat until swimming was over. Incontinent on arriving back to the [day centre] and changed in the afternoon. [Grace] relaxed before going home on the bus, see body chart.*"

Cause or explanation

9.217 Mrs. X could not recall anything about this entry, nor could she recall being contacted in relation to it. There was no evidence that she was contacted.

9.218 CW7 did not recall making that entry; however, she did say that the fact Grace had a bruise was "*concerning enough to document it.*"

9.219 However, Ms D said that there was nothing in this entry that caused her concern and that, in relation to the previous entries, there was nothing in any of the entries particularised above that caused any concern.

Finding

9.220 The evidence to the Commission did not identify the particular circumstances as to how this bruise had been sustained. However, there was no evidence upon which the Commission could find that its presence alone was an indication that Grace had been physically abused. Having regard to the matters of context set out above, the Commission is satisfied that there was ample opportunity for Grace to have

sustained such a bruise accidentally. There was no evidence to support a finding that it arose because she had been physically assaulted or abused by any person or persons.

4th March, 2009

9.221 A note dated 4th March, 2009 recorded that Grace had dried blood in her right nostril. This note also recorded that she did not appear to have any bruising and that there was no sign of blood on her clothes. The corresponding body chart was co-signed by Ms D and CW7 and indicated “[d]ried blood in right nostril of her nose, no bruising evident.”

9.222 This entry was characteristic of the level of detail and the close scrutiny of Grace at this time. This was the documenting of a small amount of dried blood in Grace’s nostril, in line with Day Service Provider A’s practice of logging and reporting any marks observed on her.

Cause or explanation

9.223 Mrs. X could not recall being contacted by Day Service Provider A in relation to this observation. There was no evidence that she was contacted about it. She said, however, when this note was brought to her attention at the Commission hearing, that the bleeding was caused by Grace’s plastic keys. Mrs. X said that Grace often had blood in her eyes and her nose because of scratching herself with the plastic keys.

Finding

9.224 The evidence with regard to this entry did not suggest that this observation of dried blood in Grace’s nostril was anything other than an ordinary occurrence. The Commission considers that there is no evidence to support a finding that it arose because of physical abuse of Grace. There was no evidence to support a finding that it had occurred because she had been physically assaulted or abused by any person or persons.

27th March, 2009

9.225 On the morning of 27th March, 2009, while showering Grace, members of staff at Day Service Provider A observed a number of marks on her body, namely three small yellow marks just above her right breast and two or three small yellow marks on her right thigh (outside), as well as scratches to her neck and upper left side. The thigh bruising which was referred to was situated 11 centimetres from the iliac crest (the hip) and it was on the outside of the leg. Ms D observed the bruises and marks herself and notified Ms B of them. The events of 27th March, 2009 and, in particular, the decisions made surrounding the discovery of these marks and scratches on Grace and the management of her case are reported upon in detail in Chapter 14 of Volume 1. The events of 27th March, 2009 are also reported upon in Chapter 4 of this Volume.

9.226 The marks and scratches were documented in a body chart and Grace was brought to the Emergency Department of Waterford Regional Hospital for medical evaluation. The body chart recorded:

“1 There are two small scratches on the right side of [Grace’s] neck where it meets her shoulder

1 There are three small circular marks which are very close together just above her right breast. These are yellow in colour and [appear] to be bruising

2 [Grace] has two small bruises on her right thigh. These bruises are very close together. They appear to be faded as they are yellow in colour...

4 [Grace] has five scratches on her left side. Three of the scratches are very close together. There are also two smaller scratches.”

9.227 The Emergency Department of Waterford Regional Hospital recorded the scratches and bruises to Grace as “*unexplained bruises and scratches*” and as “*...suspicious bruising and scratches on breasts and thighs.*”

9.228 Grace was also seen by the SATU at Waterford Regional Hospital and the doctor there was unable to come to any definite conclusion as to how the scratches and bruises on her had been caused.

Finding

9.229 Having regard to the issue that arose with respect to this presentation, in particular as to whether the marks and scratches were of a character that supported a suspicion that Grace had been subjected to sexual abuse, the Commission's findings with respect to this entry are reported at Chapter 4 of this Volume, which should be read with this Chapter.

31st March, 2009

9.230 CW6 recorded a "*small scratch on [the] left side of [Grace's] chest*" and a "*scratch on the right side of her stomach.*" Grace had been to the swimming pool and attended a 40th birthday party of another service user that day. Ms D countersigned the entry.

Cause or explanation

9.231 CW6 and CW2 had no recollection of these marks at the time of giving evidence to the Commission.

9.232 Mrs. X did not have any memory of these particular scratches, nor had she any recollection of being contacted about them by Day Service Provider A. There was no evidence that this had occurred.

9.233 There was no further investigation of these scratches at the time and no evidence that they were unusual or unexpected.

Finding

9.234 There was no evidence at the Commission to suggest that these scratches occurred in circumstances that were out of the ordinary for Grace, having regard to the circumstances in which she had scratches, as reported throughout this Chapter. There was no evidence to support a finding that they arose because she had been physically assaulted or abused by any person or persons.

2nd April, 2009

9.235 A body chart signed by CW6 recorded “*four small scratches on [Grace’s] neck.*”

Cause or explanation

9.236 At the Commission, CW6 had no recollection of these scratches.

9.237 Mrs. X could not recall them in her evidence, nor could she recall being contacted by Day Service Provider A in relation to the matter. There was no evidence that she was contacted.

9.238 There was no enquiry as to how or where these scratches had occurred. There was no other evidence available to the Commission about these scratches.

Finding

9.239 There was no evidence that these small scratches were suspicious or out of the ordinary in the context of Grace and her behaviours. There was no evidence to support a finding that they arose because she had been physically assaulted or abused by any person or persons or as a result of an injury that was not accidental.

3rd June, 2009

9.240 A body chart noted a scratch on Grace’s stomach.

Cause or explanation

9.241 There was no further evidence available to the Commission about this entry.

Finding

9.242 There was no evidence to suggest that this scratch was, in itself or by virtue of any circumstance, different to other scratches that Grace had, as reported throughout this Chapter. There was no evidence to support a finding that it had arisen because she had been physically assaulted or abused by any person or persons.

10th June, 2009

9.243 On 10th June, 2009, CW7 recorded that “... [Grace] was showered and dressed after swimming by myself, [CW7] (programme assistant). Bruise noticed on her right thigh. Body chart completed.”

9.244 A corresponding body chart was completed by CW7 on the same date, which noted “[b]lueish bruise on right thigh”.

Cause or explanation

9.245 With respect to this entry, CW7 said that, in her view, all bruising of service users was of concern.

9.246 There was no evidence of any follow-up contact with Mrs. X or of any enquiry made as to how or where Grace had sustained this bruise.

9.247 Mrs. X could not recall this particular bruise in her evidence. The Commission had no further evidence regarding this entry.

Finding

9.248 The Commission could not establish how or where this bruise occurred. From the evidence, however, there was nothing upon which it could find that its presence alone was an indication that Grace had been physically abused or that it had not been sustained accidentally, having regard to all of the contextual evidence set out above. There was no evidence to support a finding that this arose because she had been physically assaulted by any person or persons.

9.249 The above entry dated 10th June, 2009, was the last record made with respect to any mark or bruise on Grace before she was moved directly from her day placement into a residential setting linked to the Day Service Provider A facility on 17th July, 2009.

Evidence of Ms O’Sullivan

9.250 The involvement of Ms O’Sullivan, Nurse Counsellor for Parents of Children with Mental Disabilities /Advisory Nurse for the Mentally Handicapped, in Grace’s case has already been reported in the Commission’s First Substantive Interim Report.

- 9.251 The Commission also considered an aspect of the evidence which arose from a conversation that Mr. Smith had with Ms O'Sullivan on 21st August, 2007 concerning Grace's case. This is reported upon in Chapter 1 of Volume 1, and relevant parts are repeated here for ease of reference.
- 9.252 On 21st August, 2007, Mr. Smith recorded that he met with Ms O'Sullivan when she was on her way to a meeting and discussed Grace with her. He wrote that Ms O'Sullivan told him that she had visited Family X several times and had noted Mrs. X's "*rough manner*" with Grace.
- 9.253 Ms O'Sullivan could not remember the details of their conversation. She disputed Mr. Smith's record of her describing Mrs. X as having a "*rough manner*" with Grace. She acknowledged that she had said previously in evidence that Mrs. X was "*a little bit rough*" with Grace when she was trying to take down her nappy but she said that, what she meant was that Mrs. X was "*unemotional*". She said that she would have reported it immediately if she had thought that Mrs. X was rough or abusive with Grace. As stated in Chapter 1 of Volume 1, the Commission accepts Ms O'Sullivan's evidence in that regard.
- 9.254 In relation to Ms O'Sullivan's evidence, Mrs. X told the Commission that she sometimes dealt with Grace in a matter-of-fact way. She agreed that Ms O'Sullivan was "*probably*" right in that respect, but she denied ever being rough with Grace.
- 9.255 The Commission did not receive any evidence concerning the use of excessive force in the manner in the handling of Grace by Mrs. X or by anyone else in the Family X household, in the course of its investigations into Grace's care.

References to bruises following Grace's absences from her day placement

- 9.256 The concern with respect to Grace's prolonged absences from attendance at her day placement is considered in Chapter 3 of this Volume.
- 9.257 The issue of the bruising reported in Mr. M's report in April, 1996 is referred to at paragraph 9.20 above and is also reported upon in Chapter 6 of the Commission's First Substantive Interim Report. In this regard, Ms Leyshon spoke to Mr. M about Grace in February, 1999 and made a note that he told her that "[t]here were concerns in the past - whenever [Grace was] missing for a while staff would bath her on return

and [at] various times marks [were] found on her but usually an explanation and never proof that harm inflicted. .”

- 9.258 In her evidence regarding this conversation, Ms Leyshon said that Mr. M seemed satisfied with explanations given by Mrs. X for any marks on Grace's body. Mr. M told the Commission about how he had instructed staff to check her *“so that we could truthfully say that [any injury] didn't happen”* in Day Service Provider A. This was, he said, to reassure Mrs. X that Grace was all right in Day Service Provider A, rather than to investigate the origin of any injury. However, he said, they would also seek an explanation from Mrs. X or the bus driver thereafter to check if something had happened on the bus on the way to Day Service Provider A. Mr. M said that only more experienced staff, predominantly Nurse N, would be asked to make such enquiries.
- 9.259 From the evidence of the care and management staff of Day Service Provider A, it was apparent that the issue of Grace's presenting with any marks there, including if marks were observed after she came back following absences, was treated as a matter of concern.
- 9.260 Mr. M told the Commission that if there was no explanation for marks to Grace following enquiry with the bus driver, they would have been alarmed and would have wanted to know why and how such marks had occurred. However, as reported above, Mr. M said that, as far as he could recall, everything observed was explainable between Mrs. X, Day Service Provider A, and the bus driver. He said that he could not recall any instance where, in discussion with Nurse N about it, they were not satisfied or had decided that they did not believe a particular explanation given. From the documentation disclosed to the Commission, it was apparent that Nurse N had a lot of interaction with Grace and Mrs. X and that she had never raised a concern with Mr. M about the origin or cause of any particular injury.
- 9.261 Mr. M said that there was nothing that he heard by way of direct explanation from Mrs. X, or indeed from any of the other staff members arising from their interactions with Mrs. X, that left him in a position of concern or dissatisfaction or with a doubt being left in his mind with regard to the cause of marks to Grace. The matters of context with respect to Grace, referred to above, informed the background to many of the issues raised.

9.262 Asked during his evidence if it was not surprising that there was nothing recorded about Day Service Provider A's having taken steps to investigate the cause of any marks that might have been found on Grace on examination in the day centre, Mr. M told the Commission that:

"In an ideal world...you would wish that...but other people were there also looking for attention... It was...putting...out fires, action non-stop dealing with that, making a considered judgement that this was no more than what happened to my own child, you know, a scratch or whatever else. I don't need to do anything further about that."

9.263 In this regard, the records that were maintained by Day Service Provider A with respect to absences do not support any kind of clearly established pattern of injuries noted for the dates of Grace's return to the day centre after such absences. A number of notes with respect to her for dates that she returned after an absence did not include reference to any marks or bruising.¹⁰

9.264 In considering the evidence with respect to marks or bruising on Grace, the Commission has had regard to each incident as identified in the evidence, whether or not these coincided with a return by Grace to the day centre after absences from it.

Observations of minor injuries for the period following Grace's move to the residential unit in July, 2009

9.265 Following Grace's move into the residential placement on 17th July, 2009, the keeping of records and body charts to record any injuries observed on her continued. These records, examined by the Commission, evidenced that, in what was a closely-monitored residential setting, marks and bruises similar in nature to those referred to above continued to be observed on Grace.

9.266 Copies of the body charts that were completed by the staff of the local voluntary association in the period following Grace's move to residential care that were provided to the Commission showed the following:

¹⁰ For instance, 12th May, 1997, 1st February, 1999, 18th February, 1999, 8th August, 1999, 9th September, 2002, 1st November, 2004, 16th May, 2005 and 26th February, 2007.

2009: 16 entries recorded.¹¹

2010: 59 entries recorded.

2011: 118 entries recorded.

2012: 134 entries recorded.

2013: 119 entries recorded.

2014: 80 entries recorded.

2015: 27 entries recorded.¹²

9.267 A sample of the types of marks or injuries that were observed, as recorded in the body charts over the above period, is set out below:

2009

“20/7/09: Brown bruise on either side of spine.”

“31/08/09: [Grace] has what appears to be two small scratches on her chest.”

“31/08/09: [Grace] has a scratch on the left side of her back.”

“1/9/09: Bruise observed on [left] elbow.”

“1/10/09: Red mark skin starting to break forehead.”

“13/10/09: [Grace] appears to have two small bruises on her right arm.”

“19/10/90: [Grace] appears to have a triangular shaped mark on her scalp line of her head. This appears to have dry blood on it.”

¹¹ For the post-move period only, i.e. from 17th July, 2009 to 31st December, 2009.

¹² Copy body charts furnished for the year 2015 covered the period from 1st January, 2015 to 12th September, 2015 only.

"19/10/09: Laceration on head from head banging."

"20/10/2009: Red mark on [right] side of [right] thigh [indecipherable]."

"24/10/09: Small bruise on inner aspect of arm."

"9/11/09: Graze to [left] shin."

"8/12/09: Fresh bruise on upper leg/buttocks."

2010

"21/1/10: 3 x bruises on Right Knee."

"22/1/10: Small laceration on bottom lip."

"29/1/10: Middle of Back- Bruise."

"29/1/10: Over [left] Eye- Bruise."

"30/1/10: Nose - Bruise."

"7/5/10: [Grace] has what appears to be two yellow bruises on her right arm."

"21/5/10: Scratches of Front of both legs."

"18/6/10: [Grace] has a small purple bruise on Upper Right arm."

"22/11/10: Scratches observed on back."

"18/6/10: [Grace] has a small purple bruise on Upper Right arm."

"27/7/10: Open wound Scratch on back of neck."

"04/10/10: Burn on [right] thigh."

2011

“9/1/11: 2 x large bruises on upper thighs from counter”

“17/01/11: large Red mark to [left] shoulder.”

“20-1-11: Raised Red circle on upper right leg.”

“31/1/11: Red Scratch on [right] middle back.”

“9/3/11: Bruise on [left] upper arm above elbow, cause unknown.”

“29/3/11: Red mark on inner [left] Hip area.”

“7/7//11: Scratch on [left] lower back.”

“25/8/11: Red marks on upper chest.”

“15/11/11: Bruises on [right] lower leg- cause unknown.”

“1/12/11: Pressure mark on [left] side of neck.”

“13/12/11” Red mark on [left] upper leg under bottom, cause unknown.”

“28/12/11: Small abrasion on right forehead, [Grace] may have scratched in this area??”

2012

“28/1/12: four red scratches to neck.”

“20/2/12: red mark under [left] eye.”

“20/3/12: scratches on right hip.”

“15/5/12: Scratch on [right] side of stomach.”

"18/5/12: Scratches on [right] chest area."

"7/6/12: scratch mark to upper [right] Breast."

"26/6/12: Inch Red mark/Bruise to inner [right] thigh."

"30/7/12: Scratches [left] neck & front of chest."

"8/8/12: Small cut behind [left] ear- scabbed over."

"7/9/12: 3 x scratches [left] facial cheek."

"18/11/12: Scratches to [right] side of neck + chest."

"17/12/12: Several scratches on [right] abdomen & [right] upper thigh area."

2013

"7/1/13: 4 x scratches [right] abdomen."

"14/02/13: Bruise on inner [right] thigh."

"24/03/13: Bruise on [right] hip."

"16/04/13: Black bruise [lower back]."

"26/4/13: Scratches on bottom, back, [left] Leg + hip, [right] thigh."

"8/5/13: Small cut & light swelling [right] eyelid."

"13/6/13: Scratch on Lower [right] side of back."

"8/7/13: Large old bruise on [right] upper leg."

"11/9/13: Red marks on chest area."

"15/10/13: Medium size bruise on [left] upper arm, cause unknown."

"8/12/13: 3 x scratches [right] collar bone."

"29/12/13: Scratch on [right] abdominal area."

2014

"4/3/14: Scratches [mid lower back]."

"11/4/14: Bruise x 3 [rear, left, upper, inner arm]."

"3/5/14: Scratches on [right] side on collar bone."

"7/5/14: Scratches x 10 to [right] torso + stomach."

"19-7-14: Bruise x 3 [front upper left arm]."

"27/7/14: Scratches on lower neck/chest."

"12/8/14: Blister/friction mark [right] thigh."

"8/9/14: Bruise [front left thigh, above knee]."

"27/9/14: Bruise [front left upper arm]."

"6/10/14: Scratch marks [left collar bone area/ chest]."

"20/11/14: Scratches (small) [to face, above and below left eye]."

"13/12/14: Small red mark [back of upper right arm]."

2015

"15/3/15: Scratch?/ burst blister? left thumb."

"16/3/15" Bruise on [right] Rib area."

"1/4/15: Small bruise right arm."

“30-5-15: Bruise [back of left upper arm].”

“9-6-15: Graze/scratch Right hip.”

“9-6-15: Scratch [right] collar bone.”

“24/7/15: Cluster of bruises x 3 [back of right leg].”

“25/7/15: Cluster of bruises (3+) [front upper left arm].”

“5/8/15: Small bruise corner of Right eye.”

“5/8/15: Bruising along left eye lid.”

“9/9/15: Bruise [back of upper right arm].”

“12/9/15: Bruise back of [right] knee.”

9.268 Apart from the reference to the laceration to Grace's head from head-butting, there were no particular causes or circumstances recorded with respect to each entry. There was nothing in the documentation disclosed to the Commission to indicate that the manner in which Grace came by these marks and bruises was regarded as concerning or suspicious, and there is no suggestion of any kind that this was the case.

9.269 These minor injuries were broadly similar to the types of injury recorded while Grace was living with Mrs. X and attending Day Service Provider A. It is also of note that such injuries occurred following her move into residential care, notwithstanding that Grace was residing in a professionally-staffed care setting with supports and controls in place. Even allowing for the fact that Grace was agitated and upset, and exhibited deteriorating forceful behaviours associated with the onset of mental health difficulties over a period of time following her move, which may have accounted for some of her injuries, the Commission is satisfied that the records of these minor injuries and their type and locations, provided a valuable comparator to the type of injuries that Grace had been observed to exhibit from time to time over the years before her move in July, 2009.

9.270 The fact that Grace did continue to have marks and bruises in her care setting following her move in July, 2009 clearly did not, of itself, rule out that she could have sustained similar injuries through physical abuse at an earlier stage. However, that she sustained such minor injuries after her move underlined her vulnerability to accidental injuries in the course of her day-to-day life.

10. Medical records and clinical assessments

Whether concerns of abuse

- 10.1 Apart from the occasions in August, 2008 and March, 2009, when Grace was brought to Waterford Regional Hospital from Day Service Provider A, referred to above, the Commission had no evidence of any other occasion when she was presented to a nurse or doctor or hospital with any physical injury by anyone involved in either her day-to-day life or her care. This includes all SEHB/HSE personnel who came into contact with Grace and also the manager and the staff at her day placement in Day Service Provider A.
- 10.2 Over the earlier years of her placement with Family X, Grace was medically assessed on two occasions by Dr. Walsh, on 13th August, 1992 and on 24th January, 1995. These examinations are reported upon in the First Substantive Interim Report and in Chapter 3 of this Volume, which should be read with this Chapter. Neither of those examinations raised any concern about Grace's presentation insofar as it related to the question of physical abuse. On the contrary, her overall presentation from the point of view of her physical health was generally reassuring, with the notable exception of her teeth and gums.
- 10.3 The evidence of Grace's general practitioners, Dr. F and Dr. G, is also reported in Chapter 3 of this Volume. That evidence did not raise concerns of any kind about physical abuse with respect to Grace.
- 10.4 The Commission's findings regarding Grace's general health and dental problems are reported at Chapter 3 of this Volume.

11. Grace's household

- 11.1 The Commission's terms of reference on the issue of abuse raise questions with respect to the household of Family X (other than Mrs. X and Mr. X) as well as any other person, in mandating an investigation as to whether she was subjected to abuse, including physical abuse.
- 11.2 The evidence and the facts established with respect to Grace's household and the place in it of Alpha (Mrs. X's grandson), Gamma (Mrs. X's nephew), and Beta (who lived in an outbuilding on the property), together with their interactions with Grace, are reported in Chapters 3, 4 and 6 of this Volume, all of which should be read with this Chapter.
- 11.3 As reported above, there were no allegations of physical abuse made at any stage to the Commission against any of the above household members by or on behalf of any party. Further, no evidence emerged in the course of the Commission's investigations of Grace's having been subjected to physical abuse by these persons. As reported earlier, each of the above persons rejected any suggestion of such physical abuse in their evidence at the Commission.

12. Conclusions

- 12.1 In investigating the question as to whether or not Grace was subjected to physical abuse, the Commission sought to establish from the available evidence why she presented with injuries of the nature outlined above, whether or not they were as a result of her having been subjected to physical abuse and, if so, by whom.
- 12.2 In doing so, the Commission examined the occasions when marks or bruises were noted in the records of Day Service Provider A and the question of whether any pattern emerged in the evidence as to how these were sustained by Grace.
- 12.3 The presence of marks or injuries on a person of Grace's vulnerability and disability was undoubtedly a matter of concern. The fact that such marks were required to be recorded was clearly an appropriate practice on the part of Day Service Provider A. The Commission is satisfied that this had a dual purpose in Grace's case: first, to ease the day centre's communication with Mrs. X by identifying any marks or bruising that Grace had when she arrived at Day Service Provider A, as distinct from any

injury she might pick up during her day there; and, secondly, to monitor how she was on arrival. Marks and bruises were observed occasionally and it was clear from the records disclosed to the Commission and from the evidence with respect to Grace, that there were many occasions when no marks or bruising were present or observed. The Commission's findings with regard to the duty on the part of Day Service Provider A to monitor Grace are reported upon in Section 23 of Chapter 10 of the Commission's Second Substantive Interim Report.

- 12.4 The records made available to the Commission for the time after Grace was moved to residential care on 17th July, 2009 also disclosed that she sustained marks and bruises in her residential placement which were generally attributed to her own behaviours. Even allowing for the evidence with regard to the impact of the move on Grace and her behaviours, as considered in detail in Chapter 4 of this Volume, the fact that she continued to sustain marks and bruises when in supervised care reflected the challenges inherent in identifying whether marks of this nature had an innocent explanation or of themselves evidenced that physical abuse had occurred.
- 12.5 The Commission notes Mr. M's evidence that, over his time as manager of Day Service Provider A, an explanation was available for everything that was observed, either through Mrs. X, the staff of Day Service Provider A, or the bus driver. Insofar as there was evidence available to the Commission with respect to the specific entries recorded, there was nothing in the records to contradict that evidence.
- 12.6 The Commission is not satisfied that the evidence considered in this Chapter with respect to the marks or bruises sustained by Grace was such as to establish that these occurred as a result of her having been subjected to physical assaults or physical abuse, including the use of excessive force in handling of Grace, in the Family X household. There was sufficient evidence to the Commission to point to the likelihood of the injuries considered in this Chapter having been sustained in an accidental manner and in the context of aspects of Grace's presentation, her activities, or her travel to and from Day Service Provider A on the bus. Further, on the evidence, the Commission cannot rule out the possibility that, in the ordinary course of her activities, Grace may have picked up bruising at home or at the day centre or when out on an activity which showed up in the succeeding days.
- 12.7 As observed at the outset of this Chapter, the presence of marks or bruising on a child or adult with Grace's vulnerabilities and disabilities is clearly a matter of

concern. In this regard, the question also arose as to whether - in the absence of abuse being established - Grace had sustained minor type injuries of this kind by reason of a lack of care or supervision of her in her placement. However, having regard to the nature of the evidence considered by the Commission in this Chapter with respect to the occasions when injuries were noted, and the findings in paragraph 12.6 above, the Commission is not satisfied that such a finding can properly or safely be made on the evidence provided. In this regard, the Commission also takes into consideration the evidence about the type and extent of minor injuries sustained by Grace, even while in a supervised care setting, after she was moved from Family X in July, 2009.

END

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CHAPTER 3

Introduction

1. Preliminary

- 1.1 The term “abuse” is given the following meaning in the Commission's Terms of Reference:

“[A]buse” means any act, or failure to act, which results in a breach of a vulnerable person’s human rights, civil liberties, physical and mental integrity, dignity or general well-being, whether intended or through negligence, including sexual relationships or financial transactions to which the person does not or cannot validly consent, or which are deliberately exploitative. Abuse may take a variety of forms”.

- 1.2 The investigation pursuant to the Commission's Terms of Reference of the care received by Grace and “*in particular whether, and the extent to which, Grace suffered any abuse whatsoever*” from February, 1989 to 17th July, 2009 inclusive, was a broad-ranging inquiry into multiple aspects of her day-to-day life over those years, during which she lived with Family X. This encompassed the period from February, 1989 until November, 1996, when she was a child in the care of the SEHB and in foster care, as well as from November, 1996, when she reached adulthood, to the date that she was moved from the home of Family X, *i.e.* 17th July, 2009.

- 1.3 Insofar as the latter period is concerned, the following definition of “vulnerable adult”, as contained in the Terms of Reference, is relevant. It means:

“an adult who may be restricted in capacity to guard himself / herself against harm or exploitation or to report such harm or exploitation. Restriction of capacity may arise as a result of physical or intellectual impairment. Vulnerability to abuse is influenced by both context and individual circumstances.”

- 1.4 The definition of abuse, particularly given it encompasses intentional and negligent acts and omissions which result in the breach of a vulnerable person's rights and liberties, is sufficiently broad as to encompass the question of whether Grace was

subjected to abuse by way of neglect over the 20 years during which she was cared for by Family X.

- 1.5 The focus in this Chapter is on the evidence about the nature of care received by Grace both as a child and a vulnerable adult and on whether, as a matter of fact, she was subjected to neglect, (as a subset of the term “abuse” *per* the Commission’s Terms of Reference), “*whether intended or through negligence*” in the provision of her day-to-day care and needs and, if so, to establish how, where and why that occurred.
- 1.6 The question of neglect is a factual matter to be considered having regard to the nature of the evidence. By the terminology employed, neglect (whether or not “*through negligence*”) comes within the broad definition of abuse under the Terms of Reference.
- 1.7 Although the Commission’s findings on the facts established with respect to whether Grace suffered physical, emotional or sexual abuse are reported separately in this Volume, there is inevitable overlap between the evidence of those other aspects of Grace’s care and the question of neglect.
- 1.8 The details of Grace’s daily life and activities when at home or in Day Service Provider A are reported upon in Chapter 6 of this Volume and referred to throughout this Chapter.
- 1.9 In reporting the Commission’s findings on the question of whether Grace was subjected to neglect, it is necessary and appropriate, where possible to do so, to consider each significant area of Grace’s care separately, in its proper context and having regard to particular relevant factors or surrounding circumstances.
- 1.10 In investigating the nature of the care provided to Grace and in particular, the question of fact as to whether she suffered any neglect, the Commission has, at all times, had regard to her particular circumstances and care needs together with the circumstances of Family X, insofar as these were relevant to her care.
- 1.11 With respect to Grace’s care as a child in the care of the SEHB, who had been placed in the foster care of Mrs. X at the age of 11, it is also appropriate to refer to the boarding out contract signed by Mrs. X with the SEHB in relation to Grace’s

placement and its now somewhat archaic language, setting out the nature of a foster parent's duties to a foster child in accordance with its terms. For ease of reference, the text of the contract is repeated here in full:

"This Indenture made this 22nd day of February 1989 between the South Eastern Health Board (hereinafter called the health board) of the first part, and Mrs. [X] of the second part, witnesseth that the said [Mrs. X] (hereinafter called the foster parent) hereby accepts the charge of [Grace] born 24/11/78 (and hereinafter called the child); and in consideration of the sum of £34.50 per week in respect of maintenance together with the sum of NIL per year in respect of clothing to be paid to the foster-parent by the health board as hereinafter mentioned, hereby covenants and agrees to bring up the child, to endeavour to train him (her) in habits of truthfulness, honesty, obedience, personal cleanliness, hygiene and industry and in carrying out the duties of the religious denomination to which the child belongs. And the foster parent hereby binds himself (herself) to observe and keep in respect of the child, the following conditions: -

(1) The child shall be properly and sufficiently nourished and shall be suitably housed in the same dwelling house as the foster parent and kept clean in person.

(2) The child shall be adequately clothed and the foster parent shall expend a sum of not less than NIL per year on the provision and repair of clothing for the child.

(3) If the child shall at any time be suffering from illness or injury, medical aid shall be obtained for the child and if a registered medical practitioner shall advise removal to hospital, the foster parent shall cause the child to be so removed.

(4) The child shall be produced at all reasonable times to any authorised officer of the Minister for Health or of the health board when so required by any such officer; the foster parent shall furnish forthwith all such relevant information as may be required by any such officer and shall facilitate any such officer

in inspecting all parts of the house (including articles therein) in which the child lives.

(5) The child shall be restored to the custody of the health board at any time where the health board, with the consent of the Minister for Health, decide to remove the child from the custody of the foster parent or where the Minister for Health requires the health board so to remove the child.

(6) The foster parent shall cause the child to attend regularly a school in which such child will be instructed in the religion to which the child belongs, or such other school as the health board with the agreement of the nearest appropriate Minister of that denomination, may approve.

(7) The foster parent shall cause the child when of sufficient age regularly to attend religious services at the place of worship of the religious denomination to which the child belongs.

(8) The foster parent shall not insure, or attempt to insure, directly or indirectly, the life of the child and shall not have, or attempt to obtain, any interest in any insurance policy on the life of the child.

And the health board hereby covenant and agree with the foster parent that so long as the child shall continue to be boarded out in his (or her) charge the health board will pay or cause to be paid to the foster parent the sum of NIL on the day of each month in respect of the child's maintenance, and a proportionate part of such payment where the child is in the charge of the foster parent for portion of a calendar month and a sum of NIL per annum in respect of clothing for the child."

The evidence

- 1.12 During its investigations, the Commission received a substantial body of evidence, documentary and through the evidence of witnesses, about Grace's care, encompassing her overall presentation and appearance, as well as her physical health and dental care during the period from 1989 to 2009.
- 1.13 In its consideration of the above, the Commission also examined the evidence with regard to food and sustenance, as provided to Grace during her time living with Family X.
- 1.14 The evidence to the Commission did not paint one uniformly consistent picture of how Grace presented over the 20 years that she lived with Family X. It would have been unlikely for it to have done so, having regard to a number of factors likely to arise in the gathering of evidence in an inquiry on this subject over a lengthy time period.
- 1.15 The evidence received by the Commission spanned a period of 20 years. This evidence was gathered from witnesses who encountered Grace at different times and in different circumstances. Some of those witnesses encountered Grace briefly at a particular point in time, while others encountered her more regularly and sometimes on a daily basis.
- 1.16 The Commission heard evidence from Grace's carer, Mrs. X, from other members of Family X, and from visitors to the house.
- 1.17 Extensive records were disclosed to the Commission concerning the management of Grace's case, both as a child and a vulnerable adult, and the Commission heard evidence from officials of the SEHB and HSE, including the Acting Senior Medical Officer, the public health nurses, the Counsellor for Parents of Adults with Disabilities, and social workers, as well as having evidence from a social worker from the Brothers of Charity.
- 1.18 The Commission also received evidence from care staff and the management at Grace's day centre, and was provided with the available records relating to her attendances there.

- 1.19 The Commission also had the records and evidence of Grace's general practitioners over the period and the reports of psychologists, together with the evidence of a psychologist who assessed Grace in 1989 and 2008.¹
- 1.20 The Commission's consideration of the care that Grace received with regard to her physical health and dental health was by reference to the evidence received from witnesses at the Commission, which included the personnel who worked at Day Service Provider A during the time she spent there, and through available medical and dental records and records from Day Service Provider A relating to episodes or bouts of illness suffered by her.
- 1.21 Although persons who knew or encountered Grace over longer periods of time had a greater opportunity to see how she presented, the Commission also received helpful evidence from persons who had limited engagement with her and Family X.
- 1.22 There was an inevitable element of subjectivity inherent in the evidence heard regarding Grace's appearance and presentation. Witnesses gave evidence from different perspectives, and without a uniform view with respect to standards of presentation and care. Inevitably, witnesses at the Commission were often giving evidence based on their impressions of Grace and her presentation in hindsight. There was often no contemporaneous note or record available to the Commission to provide assistance.
- 1.23 This was to be expected having regard to the nature of this inquiry into the care of a person over a period of 20 years and with a starting point of February, 1989. These matters were taken into account when assessing the weight and overall reliability of the evidence, in terms of its accuracy in establishing the relevant facts with respect to Grace's care.
- 1.24 Witnesses gave evidence of events that had occurred over 20 years ago. In considering this evidence, the Commission was mindful at all stages of particular challenges faced by witnesses with regard to their memories of events, of other

¹ The psychological assessment of Grace at the age of 10 and the psychologist's evidence in respect of that assessment is reported upon in detail at paragraphs 9.22 to 9.36 of Chapter 5 of the Commission's First Substantive Interim Report. The psychologist involved in that assessment in 1989 was also listed as one of the attendees at the case conference in respect of Grace which took place on 6th October, 1989. The details of a further psychological assessment of Grace and the related report dated 29th May, 1995 are discussed in detail at paragraphs 2.44 to 2.47 of Chapter 6 of the First Substantive Interim Report. The 1995 psychological assessment of Grace is also referred to at paragraphs 5.14, 11.44 and 11.45 of Chapter 10 of the Second Substantive Interim Report.

personnel, of interactions with others, and to their knowledge and awareness of issues over the timeframe under investigation. These were concerns almost inevitably to be encountered in an investigation commencing in 2017 into matters occurring during the period of time under consideration in this report.

- 1.25 Many witnesses giving evidence had long retired, while some had moved to other employment. The Commission has, where relevant, had regard to issues of age, frailty, ill health and other life circumstances impacting upon the giving of evidence and the clarity of witnesses' recollections. The Commission's considerations on matters relating to the memory of witnesses are set out in Chapter 1 of the Commission's First Substantive Interim Report.²
- 1.26 In reporting on the question of whether Grace was subjected to neglect, the Commission has considered all of the evidence provided in the course of its investigations in Phase One of its work about Grace and her care. Phase One of the Commission's investigations does not include investigations into allegations made by or on behalf of other individuals about their care while staying with Family X.
- 1.27 The Commission is satisfied that in Phase One of its investigation, it has taken evidence from relevant persons who came into contact with Grace during the period when she was placed with Family X and elicited any observations they may have had with respect to her in Family X's home or otherwise during that period. This has included a consideration of persons who came into contact with Grace through Family X's respite service, both on a public and private basis, during that time and who could provide evidence concerning Grace. The Commission is satisfied that, insofar as Grace is concerned, its investigations have been sufficiently comprehensive as to capture available evidence pertaining to Grace's care during that period, and with respect to whether there was evidence that she was neglected, that being the subject matter of this Chapter.

2. Chapter overview

- 2.1 On consideration of the evidence, the Commission is satisfied that the following aspects of Grace's care are the aspects to be considered and reported upon in

² The First Substantive Interim Report is dated 11th January, 2021. The Commission's considerations on matters relating to the memory of witnesses are set out at paragraphs 6.1 to 6.4 of Chapter 1 of it.

establishing the facts as to whether she suffered neglect over the 20 year period reported upon by the Commission:

- Grace's presentation;
- Grace's weight;
- Grace's level of attendance at her day placement;
- Grace's dental health; and
- Grace's general physical health.

3. Matters of context specific to question of neglect

- 3.1 Before examining the specific aspects of Grace's care outlined above, it is important to take account of the matters of context specific to the question of neglect. The investigation of events concerning the question as to whether Grace was subjected to neglect could not be undertaken without taking into account the reality of her life and the lives of her carers.
- 3.2 Those specific matters of context are relevant considerations in arriving at a proper understanding of aspects of the evidence that concerned Grace's day-to-day appearance, her personal care needs, and how she presented in her daily life.
- 3.3 General matters of context relating to Grace and her environment that required to be taken into consideration by the Commission are discussed in the Introductory Chapter and Chapter 2 of this Volume. These include contextual matters relevant to Grace's characteristics, behaviours and challenges, and derive from the extensive evidence that emerged throughout the course of the Commission's investigations.
- 3.4 The extent of Grace's care needs and her vulnerabilities associated with her profound intellectual disabilities have been reported in both the First and Second Substantive Interim Reports.³

³ The Commission's Second Substantive Interim Report is dated 29th March, 2021.

3.5 The relevant contextual matters to be considered for the purposes of this Chapter are as follows:

- Grace's level of dependence;
- Mrs. X's qualifications and training;
- Concerns expressed about the ages of Mr. and Mrs. X;
- Mrs. X's stance as an ageing carer;
- Grace's incontinence; and
- other background information.

Grace's level of dependence

3.6 Grace, as somebody who was born with microcephaly, required full-time assistance with almost every aspect of daily living. This included dressing, toileting, personal care, bathing, washing, oral hygiene, grooming, bedtime, provision of meals and any daily activities. By virtue of her condition, Grace's level of dependence on others was total. Her day-to-day care needs were high.

3.7 Grace could not travel alone and needed someone with her whenever she was out of her home. Up to the time she started to travel by bus to Day Service Provider A at 16 years of age, Grace had never travelled anywhere unaccompanied or with strangers.

3.8 Grace's experience of travelling to and from Day Service Provider A from September, 1995 to July, 2009 is reported upon in detail in Chapter 2 of this Volume. This is also reported in the First Substantive Interim Report.

Mrs. X's qualifications and training

3.9 The position regarding Mrs. X's registration as a childminder in England in the 1980s is reported at paragraphs 10.133 to 10.137 of Chapter 4 of the First Substantive Interim Report. The Commission is satisfied that the reality of the situation was that, while Mrs. X had some experience in minding children with disabilities in Ireland, she

did not have any formal training or expertise in the physical care requirements of persons with profound intellectual disabilities, such as Grace.

- 3.10 Regarding how she came to work with children with disabilities in Ireland, Mrs. X told the Commission that, at some point in the early 1980s, she was contacted by the mother of a local *“handicapped girl”*. Mrs. X believed that she had originally met the mother in the shops in the local village. Mrs. X said that, at first, she looked after the girl, who was 14 years of age, when her parents went on holiday to England and that, after their return, she began to look after her on a more regular basis.⁴
- 3.11 Mrs. X said that she had no experience of minding *“handicapped children”* prior to that but she told the Commission that she had always been *“drawn”* to handicapped children and that she had agreed to mind the child.⁵
- 3.12 Mrs. X also had no expertise or training of any kind to deal with the attendant behavioural patterns, level of understanding, communication issues and the psychological factors inevitably associated with Grace’s level of intellectual disability.
- 3.13 From the commencement of Grace’s placement with Family X in February, 1989, the day-to-day care of Grace and the decisions that fell to be made concerning her living circumstances, from diet to choice of clothing to personal care, the management of her incontinence condition, her behaviours, and her day-to-day needs were left to Mrs. X’s discretion. Some of these were adverted to in the contract, whereas others could have been expected to have been attended to by Mrs. X in any event as part of day-to-day care and by virtue of her experience as a childminder.
- 3.14 The limited extent to which Grace’s placement was monitored by the SEHB and HSE from the date of Grace’s placement in 1989 to the beginning of 2006 has been reported throughout the First and Second Substantive Interim Reports.

Concerns expressed about the ages of Mr. and Mrs. X

- 3.15 From a very early stage of Grace’s placement with Family X, questions were posed within the SEHB about the long-term suitability of the placement. The age of Mrs. and Mr. X, in terms of their ongoing capacity to provide long-term care for Grace (having

⁴ See paragraph 8.15 of Chapter 4 of the First Substantive Interim Report.

⁵ See paragraph 8.16 of Chapter 4 of the First Substantive Interim Report.

regard to Grace's high care needs), was an issue that was raised intermittently within the SEHB/HSE when Grace's case came under consideration over the following 20 years.

- 3.16 The first reference to this was six months after Grace was placed into foster care with Mrs. X, when Ms Kitty Greaney, Children's Officer in the SEHB, prepared a letter dated 20th September, 1989. Ms Greaney's concern was set in the following context:

"Finally: [Grace] continues to live with Mr & Mrs [X]... her management is coped with extremely well by the family but Mr [X] is almost 70 years of age, and whilst he and his wife were excellent foster parents, with an insight into mental handicap...The atmosphere within the home is loving and easy going but I would pose a few questions.

(a) The lack of other children for [Grace] within in the home;

(b) The age of the foster father;

(c) The fact that [Grace] is not school going;

(d) What if another child like [Grace] comes on stream without paternal support;"

- 3.17 At that stage, Mrs. X was 53 years of age and Grace was nearly 11 years of age.

- 3.18 In a report prepared by Ms Greaney on 26th February, 1992 as part of an application to Residential Facility A to have Grace admitted to residential care, Ms Greaney (although describing Grace as a happy affectionate child who posed "no management problems") advised that it was her "considered opinion, given [Grace's] age and the age of her foster parents (Mr. [X] is about 70 years old) that placement at [Residential Facility A] would be more practical in the long run."

- 3.19 At that stage, Mrs. X was 55 years of age, Mr. X was just 70, and Grace was 13 years old.

- 3.20 As reported in the First Substantive Interim Report, it appeared to have been a feature of Ms Greaney's relationship with Mrs. X that Ms Greaney sought to maintain and encourage Grace's foster placement while simultaneously pressing periodically to secure a more suitable placement for her long-term needs.⁶
- 3.21 Speaking of a potential placement in Residential Facility A in 1992, Dr. Martin O'Boyle, Acting Director of Community Care in the SEHB from 1987 to 1995, said that *"it may not have been perfect but I mean you are looking at a child who was in a place that couldn't continue much longer... and she had to find some place where she could sort of begin to grow up."*
- 3.22 As reported in the First Substantive Interim Report, the focus of medical, psychiatric and psychological assessments referred to during that early period of Grace's time living with Family X was on Grace's need for a day placement, and also the view that her overall needs would be best met in a residential placement.
- 3.23 Regarding a medical examination of Grace carried out by the Acting Senior Medical Officer with the HSE, Dr. Elizabeth Morrissey Walsh in January, 1995, Dr. Walsh recalled in evidence that the review was conducted *"to review her current placement in view of the age of the foster parents, but as well there was a point along the way where I became aware that [Mr. X] had health issues."* This was a reference to Mr. X's diagnosis with Parkinson's disease.
- 3.24 In her evidence about the meeting in April, 1996, when it was decided to move Grace into residential care, although Dr. Walsh did not recall the issue of age and ill health of Mrs. and Mr. X being discussed, she said that it was *"an issue on the horizon for a few years"*. In this regard, Dr. Walsh recalled that the purpose of carrying out a medical examination on Grace in August, 1992 was in connection with forward planning for residential care when Grace turned 18.⁷
- 3.25 With respect to the decision in April, 1996 to move Grace to an alternative placement, Ms Sandra Merity, then the Senior Social Worker in the Waterford Community Care area, made a note at that time that *"the decision to look for an alternative placement was taken on the basis (i) this move had been discussed*

⁶ See paragraphs 9.15 and 19.10 of Chapter 5 of the First Substantive Interim Report.

⁷ This meeting and the management of Grace's case by the SEHB in 1996 has been reported at paragraph 11.9 of the First Substantive Interim Report.

previously with the [Xs] due to the suitability of the placement to meet [Grace's] needs (age + ill health) (ii) given the allegation it was felt that [Grace] needed to be protected and given the fact that she is in the health board's care that the health board had to take reasonable steps to protect her."

- 3.26 As reported in the First Substantive Interim Report, there was no explanation offered by the attendees of the October, 1996 case conference concerning Grace for their departure from the long-term plan for Grace, namely that, having regard to the age of Mr. and Mrs. X and Mr. X's ill health, Grace's welfare would best be provided in an institutional setting.⁸
- 3.27 In her evidence on the question of the option of shared care offered to Mrs. and Mr. X in September, 1996, Dr. Walsh told the Commission that, apart from any child protection concerns, in her view, things could not have continued the way they were with Grace's staying with Family X. She said that "[Mr. X] *was becoming elderly, in ill health, and it was felt that the situation couldn't continue and the other thing was there was the place available with the decision made early on that [Grace] should avail of residential care*".⁹
- 3.28 The age of Mrs. and Mr. X and their ongoing ability to care for Grace continued to be raised as an issue over the period between 1997 and June, 2000 (relating only to Mrs. X after Mr. X's death in June, 2000), before Grace's case completely fell off the radar of the SEHB/HSE, a state of affairs reported upon in Chapter 10 of the Second Substantive Interim Report.
- 3.29 Ms Helen O'Brien, who held the position of SEHB key worker for Grace from the end of 1996 to 1997, said that she assessed Grace's case as one of medium priority owing to the requirement for ongoing monitoring as a result of the allegations that had previously been made, the age of Mr. and Mrs. X, and the nature of Grace's disability.¹⁰
- 3.30 The fact that "*Mr. and Mrs. [X]'s situation is that they are in their 60's (Mrs.) and late 70's, early 80's (Mr.). Mr. [X] has Parkinson's Disease*", as observed at the meeting

⁸ See paragraph 19.54 of Chapter 7 of the First Substantive Interim Report.

⁹ See paragraph 17.51 of Chapter 7 of the First Substantive Interim Report.

¹⁰ See paragraph 8.28 of Chapter 10 of the Second Substantive Interim Report.

on 22nd February, 2001 of core professionals with an involvement in Grace's case, continued to be a highlighted feature in discussions about Grace's ongoing care.¹¹

- 3.31 A professional workers' meeting was convened on 21st March, 2001 in order to *"consider the long term care for [Grace] in light of the changed circumstances of her fostering arrangement which has come to light since the previous meeting i.e. Mr. [X] having died of a heart attack in June, 2000."* An aspect of the discussion at this meeting *"revolved around Mrs. [X's] relationship and standard of care of [Grace] and consideration given to [Grace's] long term best interests given Mrs. [X's] age in her 60's"*.
- 3.32 In this regard, Ms Catherine Hogan, SEHB Coordinator of Disability Services from 1998 to 2001, agreed that there was a discussion about Mrs. X's relationship and standard of care of Grace, as well as Grace's long-term best interests given Mrs. X's age at that time.
- 3.33 There was little or no evidence as to what specifically was taken into account at that stage when referencing *"standard of care"*. In this regard, the Commission notes the evidence of Ms Frances Jones, SEHB social worker, when she spoke about a home visit that she made in January, 1999 and described Grace as being *"close to the line of needing extra care in terms of hygiene, in terms of stimulation, in terms of meeting more people."*
- 3.34 Many years later and after Mr. X had died, following a Person-Centred Plan ("PCP") meeting at Day Service Provider A on 3rd July, 2009, Ms Caroline Burke, Independent Advocate, highlighted her concerns with respect to Grace's personal care and future planning, observing that *"[a]s [Mrs. X] is ag[e]ing I would have concerns about [Grace's] care placement going forward. What plans have been put in place in the event that something happens to [Mrs. X]?"* That was when Mrs. X was 71 years of age and Grace was 30. The PCP meeting is reported upon below.¹²

¹¹ See paragraph 13.3 of Chapter 10 of the Second Substantive Interim Report; Mr. X was not alive by this time; he died on 24th June, 2000.

¹² The PCP meeting is also reported on in Chapter 17 of Volume 1.

Mrs. X's status as an ageing carer

- 3.35 It is a statement of the obvious that as Mrs. X aged in the aftermath of Mr. X's death in June, 2000, Grace's daily physical care needs did not lessen or abate. This is a relevant contextual factor in considering the evidence about the standard of the day-to-day care of Grace as the years went on.
- 3.36 The pattern, from the commencement of Grace's placement with Family X, was that Mrs. X did not seek assistance or respite or support with respect to any aspect of the provision of Grace's care. The Commission is satisfied that Mrs. X considered herself to be the person who could take care of Grace and did not welcome any "interference" in that regard. Her evidence was that Grace was better off with her at home, rather than in residential care of an institutional kind. Mrs. X did not see or acknowledge any shortcomings in the standard of her day-to-day care of Grace.
- 3.37 The Commission is also satisfied that Mrs. X's awareness of the plan to move Grace from her care, which periodically surfaced for consideration with the SEHB/HSE, was, in all likelihood, a significant factor in her mind at all times. She did not want Grace to be removed from her care. In this regard, the Commission is satisfied that Mrs. X was never inclined to seek any assistance or to draw any attention to Grace's care needs that might lead to reactivation of any plan to remove Grace.
- 3.38 Insofar as the day-to-day care of Grace was concerned, the Commission is satisfied, on the evidence considered, that Mrs. X's age was a factor relevant to the standard of care provided to Grace.

Grace's incontinence

- 3.39 Urinary incontinence and faecal incontinence were issues that Grace endured from a young age. She was affected by both types of incontinence and was not toilet-trained before she came into foster care with Family X at the age of 10. It is apparent from the evidence that Grace's incontinence and its management was an ongoing challenge for Mrs. X. Grace had to be changed frequently and used incontinence wear at night. Showers and baths were regularly required at different times during the day and, according to Mrs. X, Grace was showered routinely every evening before she went to bed. Grace had regular episodes of incontinence on the bus on the way to Day Service Provider A and often needed to be changed and showered when she arrived there. She also had episodes of incontinence and soiling during the day while

at Day Service Provider A and needed to have her clothes changed and laundered when that happened. The matter of Grace's incontinence is reported upon in further detail in Chapter 2 of this Volume.

4. Other background information

The house and surroundings

- 4.1 The home of Family X, an old style countryside dwelling, was a quaint house set in a picturesque location with a river running to the back of the house. There was a natural waterfall flowing under the laneway and emerging as a stream. Previously there was a mill located over the stream and a turbine to operate it. There was a garden to the front and back of the house, a small gate with a pathway to the front, and a larger gate with access to an enclosed yard. There was another gate providing access to an area outside the site where firewood was cut and stockpiled by Mrs. X's nephew, Gamma. A minor road ran along the side of the property.
- 4.2 The house was only 0.4 km from the local village and there were houses nearby, with an enterprise of some note a short distance from the house.
- 4.3 The house was in a rural setting but not isolated in the sense of not having passing traffic and it was not uncharacteristic of many houses in similar settings throughout the Irish countryside. In this regard, the reference to the property as isolated, made from time to time in the evidence, was not an accurate description of the position.

The setting

- 4.4 The setting and surroundings of Family X's house were lauded by Ms Greaney and by Ms Martina Doyle, Social Worker, Brothers of Charity, when children were first due to be placed with Family X for respite and also at the time of Grace's placement with Family X.
- 4.5 As referred to in the Commission's First Substantive Interim Report, in a letter to Ms Greaney dated 15th May 1985, Ms Doyle stated that: *"This family live in a small two storey house to which they have added many extensions. They live in a very rural setting with the garden which includes the play-house all of which make it a very ideal setting for children..."*.

- 4.6 As reported in the Commission's Second Substantive Interim Report, after Ms Frances Jones, SEHB social worker, visited the house in 1999, she described it as resembling an old English cottage with a garden that was slightly overgrown, and not "*ideal*" for Grace.
- 4.7 Ms Dianne Leyshon, Social Worker for Adults with Intellectual Disabilities with the SEHB, described the house as being in the country and very hard to find. She thought it quaint and old-fashioned. However, Ms Leyshon said that it was clean, adequately furnished, and seemed comfortable with a big garden. She agreed with the description of the garden as being like an English cottage garden and a little bit overgrown.
- 4.8 On a visit in September 2007, Ms Eileen Griffin, HSE Liaison Social Worker, recalled a beautiful cottage on a picturesque hill, while Mr. Iain Smith, Social Work Team Leader, HSE, described it as a "*typical granny's house*" and as being "*full of old knick-knacks and bits [and] pieces.*" Mr. Smith concluded that it was good accommodation and a comfortable looking house.
- 4.9 With respect to the location where Family X lived, Mr. M of Day Service Provider A said he kept hearing about "*this isolation*", but pointed out the proximity of the aforementioned enterprise (which has not been identified in this report to protect the anonymity of the location of Family X's house) with lots of activity. The house was not, he said, cut off.
- 4.10 Ms. Helen Hawe, Public Health Nurse, SEHB did not think that the location of Family X's home was very secluded. She surmised that, if one was from the country, as she was, one would not have regarded it as being secluded because it was very close to the village. It was a lovely house, she said, adding that it was similar to the type of house that one would find in the Cotswolds. There were roses growing up the front and a little stream running nearby. She told the Commission that she did not see anything wrong with the house, as regards its suitability for Grace to live in.
- 4.11 Ms Kathleen O'Sullivan, Nurse Counsellor for Parents of Children with Mental Disabilities with the SEHB, recalled the house as being in a wooded area with trees around it. Visiting in the winter, she described her first impression of it as "*dark, dull, kind of claustrophobic*".

The “Breakaway Scheme”

- 4.12 As set out at paragraphs 8.29 and 8.30 of Chapter 4 of the First Substantive Interim Report, by the summer of 1984, five years before Grace was placed into Mrs. X’s foster care by the SEHB, the Brothers of Charity had begun to place children with Mrs. X for periods of two weeks throughout the months of July and August on temporary “boarding out” contracts. This was known as the “Breakaway Scheme” or the “Holiday Placement Scheme” or the “Scheme” and it ran from 1984 to 1990. The Breakaway Scheme was funded, in part, by the SEHB, with the balance of the money coming from the children’s parents as a proportion of the Disability Allowance they received. During the currency of the Breakaway Scheme, Grace lived with Family X from 1989 to 1990.
- 4.13 A concern arose in 1991 on the part of the Brothers of Charity about the fact that there were other placements with Family X at the same time as children were being placed there on the Breakaway Scheme.¹³
- 4.14 Mrs. X told the Commission that she stopped doing the Breakaway Scheme because a friend of hers had asked her to mind her intellectually disabled daughter (who was the same age as Grace), when required. This person stayed with Family X initially on a “*needs must arrangement*” beginning in 1992 and later for five days and nights *per* week from 1999 to 2013.
- 4.15 Mrs. X told the Commission that she wrote to Ms Doyle to let her know that she was not participating in the Breakaway Scheme any longer, as she had someone coming to stay with her that would keep Grace company.
- 4.16 A letter sent by Mr. X to the Brothers of Charity stated that Family X would not be taking part in the Scheme because Mrs. X was tired. The Scheme came to an end when Family X, which was the sole host family, declined to participate in it in 1991.
- 4.17 The Commission has established that the number of children who stayed in the house for short periods while Grace was there was, on average, two children *per* week, from July to August in 1989 and 1990.

¹³ The Commission’s report on this aspect is set out at paragraph 8.38 of Chapter 4 of the First Substantive Interim Report and in Volume 5 (generally referred to as the SEHB Investigation Volume). They should be read with this Section.

- 4.18 After the Breakaway Scheme had come to an end, Ms Doyle wrote on 2nd December, 1992 to Mr. Pat Conaty, the Senior Social Worker with the SEHB, expressing concern about the continued placement of children with Family X *“through the Health Board channels and also by private arrangement”*.¹⁴
- 4.19 Ms Doyle had heard that families were making private arrangements with Family X for their children to be placed with them in the short term. She told the Commission that the purpose of her letter was to inform health board personnel who might have been involved in any way with Family X that there were private arrangements being made with families. Ms Doyle said that she was seeking to ensure that people knew that placements were being arranged privately as well as through health board channels.
- 4.20 The documentation disclosed to the Commission included a memo dated 4th December, 1992 noting the following:
- “[Ms Doyle] concerned about using [Family X] - based on factual reports + on ‘grapevine’ information...official [health board] placement and also on-going private placement. [Query] level of care / space? Lack of info re other placements. [Query] failure to notify each worker involved. [Query] lucrative business.”*
- 4.21 The Senior Social Worker wrote to Ms Doyle on 23rd February, 1993, referring to her letter of 2nd December, 1992, and confirming that *“following investigations there is no evidence to the best of our knowledge that there has been any neglect to the children in the care of Mr. and Mrs. [X].”*¹⁵ The Senior Social Worker’s investigation did not examine Grace or consider her position at all.¹⁶
- 4.22 Ms Doyle gave evidence that she had been concerned about the number of children staying at the home of Family X and whether this was *“overburdening the system”*. Ms Doyle said, however, that she *“wouldn’t have had a query about the level of care”*. Ms Doyle did not express a concern regarding the standard of care of Grace, save with respect to the very important matter of her not having any educational-type

¹⁴ This is a matter reported upon at paragraphs 11.4 and 11.5 of Chapter 5 of the First Substantive Interim Report and in Volume 5.

¹⁵ The investigations in question were also prompted by a letter which Ms Doyle had written in late December, 1992 to Dr. Walsh in respect of a specific child, Z.Z., which is reported on in the SEHB Investigation Volume (see also below at paragraph 4.24 et seq.).

placement. Ms Doyle's involvement in this aspect of Grace's case is reported in greater detail at Chapter 5 of the First Substantive Interim Report.

- 4.23 It might be observed that the more placements there were with Family X at any one time, the more likely that was to impact upon the quality of day-to-day care and attention provided to Grace, at least up until she began attending Day Service Provider A in September, 1995. Undoubtedly, the more children there were in the house, the greater the burden of work there would have been in providing Grace with good and proper care and individual attention.

SEHB investigation

- 4.24 Specific concerns about the care of another child who stayed with Family X over periods from 1988 to 1993 were notified to the SEHB by Ms Doyle in December, 1992. There was an investigation with respect to these allegations within the SEHB at that time. In accordance with its Terms of Reference,¹⁷ the Commission inquired into matters pertaining to that investigation. The manner in which those allegations were treated by the SEHB in 1992/1993 is reported in the SEHB Investigation Volume, which should be read in conjunction with this Chapter.
- 4.25 Aspects of those allegations investigated by the SEHB concerned the child's dishevelled appearance, her condition and her poor overall presentation at her day placement when she came directly there from Family X's house.
- 4.26 When he gave evidence to the Commission, Mr. Conaty, who had conducted the investigation, recalled making his views known at the time that Family X should not have had more than three children staying with their without first registering with the health board, saying it would have been "*too much for them*".
- 4.27 Insofar as Grace was concerned, there was no evidence to the Commission that any specific concern about the level or the quality of care being provided to her by Mrs. X and Family X was raised within the SEHB or by the Brothers of Charity at that stage. The evidence in this regard was that Grace's situation in the house was simply not considered at all in the course of the SEHB's investigation.

¹⁶ See the SEHB Investigation Volume (Volume 5).

¹⁷ Term of reference IV. d)

- 4.28 The evidence to the Commission was that there were a number of children who stayed with Family X for short periods from time to time on a private basis after the cessation of the Breakaway Scheme in 1990. These temporary private placements included the child referred to at paragraph 4.14 above. How Grace's care, in particular the quality of that care, may have been impacted by the number of service users that were in the house at any given time could not be precisely determined.
- 4.29 The Commission made contact with a number of service users who had stayed with Family X at the same time as Grace and whom it considered might be able to provide useful information about Grace's care there during that period.
- 4.30 In that regard, the Commission identified and contacted a number of service users who had stayed with Family X in 1989 and 1990 under the Holiday Placement Scheme. None of the service users who responded to the Commission was in a position to provide any material information about Grace in her home setting with Family X. The Commission also had evidence from a number of persons unconnected with the Holiday Placement Scheme who encountered Grace in her placement and who had some memory of her there.

5. Grace's presentation

Preliminary

- 5.1 Grace's presentation takes into account her overall appearance, her clothing, hair, cleanliness, and general hygiene. These aspects are considered by reference to the evidence received from witnesses at the Commission, and through records and documentation, where available.

Layout of evidence regarding Grace's presentation

- 5.2 In considering the layout of this Section, the Commission found that the most efficient way to present the evidence was to consider each witness's assessment of Grace's presentation, that is, her appearance, clothing, hair, cleanliness, and general hygiene, where available.
- 5.3 For the purpose of this Section, some of the witnesses have been grouped according to their place of employment, as well as by specific time periods. Others have been grouped according to their connection to Grace. It should be noted that some

witnesses were in a position to give evidence on one or more topics or events while others were not.

5.4 As already noted, there is inevitable crossover in the evidence of witnesses concerning different aspects of Grace's presentation and the emergence of any concerns of neglect, with the added feature that some witnesses were in a position to give evidence on one topic or event, while the evidence of others was wider in its scope.

5.5 The Commission has, therefore, approached the layout of evidence reported in this Chapter by considering the relevant evidence pertaining to Grace's presentation under the following headings:

- February, 1989 to November, 1996 - SEHB evidence;
- December, 1996 to July, 2009 – SEHB/HSE evidence;
- September, 1995 to July, 2009 - local voluntary association evidence;
- February, 1989 to July, 2009 - evidence of Family X and other household members which related to the entire period that Grace was in the placement with Family X;
- evidence of other persons who encountered Grace in the placement with Family X at particular times; and
- evidence of personnel regarding Grace's presentation on arrival at her new residential placement on 17th July, 2009.

February, 1989 to November, 1996 - SEHB evidence

5.6 Grace was a foster child with Family X during the period from February, 1989 to November, 1996, when she turned 18 years of age. The Commission's findings with respect to its investigations pursuant to the Terms of Reference concerning the management of her case by the SEHB over this period have been reported in the First Substantive Interim Report. Notably, in the many professional reports prepared about Grace for and within the SEHB during this period, there were no references to

any feature of her physical presentation, clothing or appearance that raised a concern that she was receiving poor care or that she was being neglected in her placement.

- 5.7 On the contrary, those professional reports were reassuring and, at times, complimentary of the care that Grace was receiving from Mrs. X and with Family X.¹⁸ An important exception to this were the references to the condition of Grace's teeth which arose in a number of the reports, though this was not observed in the context of indicating poor care or neglect over this period. This particular aspect of Grace's care is reported upon below in Section 9, dealing with Grace's dental health.
- 5.8 In the evidence heard by the Commission, none of the SEHB personnel who met Grace or who visited Family X's house or met with Mrs. or Mr. X between February, 1989 and November, 1996, raised a concern at any stage with respect to Grace's presentation.¹⁹
- 5.9 A significant part of the picture that emerged concerning Grace's care from the time that she was placed with Family X up until she became an adult in 1996, in particular her appearance and presentation up to the age of 16 (when she commenced attending at Day Service Provider A), was drawn from the facts established on consideration of the above professional reports and the evidence of the above witnesses.

December, 1996 to July, 2009 - SEHB/HSE evidence

- 5.10 The evidence of SEHB and HSE personnel who had involvement in Grace's case over the period from January, 1997 to 2007 has been reported upon in the Commission's Second Substantive Interim Report. The very limited nature of the contact with Grace and the fact that she was not seen by any official from the SEHB/

¹⁸ See the report of Mr. Enda McGovern, Clinical Psychologist with the Brothers of Charity (dated 3rd August, 1989) (paragraphs 9.22 to 9.29 of Chapter 5 of the First Substantive Interim Report); the psychiatric assessment of Grace (on 18th August, 1989) (paragraph 9.37 of Chapter 5 of the First Substantive Interim Report); the report of Dr. Elizabeth Walsh (dated 13th August, 1992) (paragraphs 10.70 to 10.75 of Chapter 5 of the First Substantive Interim Report); Ms Greaney's letter prepared ahead of the case conference (dated 20th September, 1989) (paragraph 9.41 of Chapter 5 of the First Substantive Interim Report); and Ms Greaney's "*social report*" dated 26th February, 1992 (paragraphs 9.59 to 9.62 of Chapter 5 of the First Substantive Interim Report). These are discussed in detail in Chapter 5 of the First Substantive Interim Report. Dr. Walsh's 1995 medical report on her examination of Grace on 24th January, 1995 is reported upon in Chapter 5 (paragraphs 10.76 to 10.77) and in Chapter 6 (paragraphs 2.25 to 2.32) of the First Substantive Interim Report. The report of the clinical psychologist who saw Grace on 13th April, 1995 (dated 29th May, 1995) is reported upon in Chapter 6 (paragraphs 2.44 to 2.54) of the First Substantive Interim Report.

¹⁹ The SEHB witnesses who came into contact with Grace or who met with Mr. and Mrs. X during the above period, and who gave evidence at the Commission, included Dr. Elizabeth Walsh, Ms Geraldine Kelly (Social Worker), Ms Kathleen O'Sullivan (Nurse Counsellor for Parents of Children with Mental Disabilities), Nurse Helen Hawe, and Ms Sandra Merity (Senior Social

HSE from 20th April, 2001 until 2007 and, in particular, that there were no visits to her placement with Mrs. X from that date until the visit paid by Mr. Smith and Ms Griffin in September, 2007, is detailed in that interim report.

- 5.11 Evidence specific to the issue of Grace's presentation received from SEHB/HSE officials over the period from December, 1996 to July, 2009 is referred to below on a witness-by-witness basis.

Ms Helen O'Brien

- 5.12 In 1997, Ms Helen O'Brien was job sharing the SEHB position of Social Worker for Adults with Intellectual Disabilities with Ms Frances Jones (whose evidence is reported on below) on a week-on week-off basis. Ms O'Brien became directly involved in Grace's care in that role when Grace reached 18 years of age in November, 1996. She said that she was then appointed key worker for Grace. Ms O'Brien said that she believed her function as key worker was to maintain regular contact with the family of the service user in order to ensure the well-being of the person.²⁰
- 5.13 Ms O'Brien did not recall the number of times she visited Grace before September, 1997, when she handed Grace's case over to Ms Jones. She told the Commission that she could not say *"that it was as frequent as one would like because of the demands of the role, the demands on the service"*. Ms O'Brien could only recall meeting Grace on one occasion when visiting Family X. She thought that Grace might have arrived home from Day Service Provider A while she was there. She recalled chatting to Mrs. X and that it had been a comfortable exchange.
- 5.14 Ms O'Brien recalled another occasion of observing Grace at Day Service Provider A. She told the Commission that Grace looked healthy and well presented. She did not recollect her being in old-fashioned clothes or her hair being greasy, dirty or matted. She said that she had no recollection of Grace's clothes being dirty or age inappropriate. She did not recall anything about her teeth.

Worker).

²⁰ See paragraph 6.16 of the Second Substantive Interim Report.

5.15 Ms O'Brien told the Commission that, from her observations of Grace when she saw her on occasions between October, 1996 and September, 1997, and from the information that was coming to her at that particular time, she did not have any concerns about her physical condition or her physical presentation.

Ms Helen Hawe

5.16 Ms Helen Hawe was a SEHB public health nurse who, in 1995, covered the area where Grace lived.²¹

5.17 Ms Hawe gave evidence of seeing Grace on occasions when she visited the home of Family X a number of times between August, 1995 and February, 2001.

5.18 When she was asked for her first impression of Grace, Ms Hawe told the Commission that she looked thin but that she did not have any concerns about her. She also said that she felt Mrs. X was very protective of Grace.²²

5.19 On one such visit, sometime between 1999 and Mr. X's death in June, 2000, Ms Hawe called to the home of Family X in the evening. She told the Commission that this was unusual, in that she usually visited the house in the morning, when Grace was at Day Service Provider A for the day. On this occasion, Ms Hawe recalled Grace's coming off the bus and Mrs. X's placing her arms around her, bringing her into the house, and sitting her down. Ms Hawe recalled Grace as very thin, but she said that this was Grace's whole "*make-up*". She said that she did not have any concern as to how Grace was dressed. Reflecting on this during her evidence to the Commission, Ms Hawe said that she would have noticed "*straight away*" if Grace's clothing was not right. Describing Grace's mode of dress, Ms Hawe remembered her wearing pants, such as leggings, and a jumper.

5.20 Ms Hawe also gave evidence about a note made in January, 1999 by Ms Jones, which referred to Grace's having gum disease and to her discussing this with Ms Hawe. Although she did not recall the discussion with Ms Jones, Ms Hawe told the Commission that Grace's teeth "*wouldn't have been great really*". She thought that she had possibly observed this on the visit, referred to above, where she saw Grace

²¹ See paragraph 1.6 of the First Substantive Interim Report.

²² Ms Hawe's visits to the home of Family X are reported upon in the First Substantive Interim Report.

after she came in off the bus. The condition of Grace's teeth is reported below in Section 9, dealing with her dental health.

- 5.21 In a note of 23rd February, 2001, Ms Leyshon recorded a telephone call with Ms Hawe, who had visited Family X that day. Ms Leyshon noted that that Ms Hawe told her that Grace had been kept at home as she had been banging her head on the bus. Ms Leyshon also recorded that Ms Hawe had "*no concerns*" about Grace's care other than the fact that Grace "*did seem to be a bit thin*".

Ms Frances Jones

- 5.22 Ms Frances Jones was a SEHB social worker. From September, 1997, she worked part time as a social worker in the Learning Disabilities Service. She was key worker in Grace's case from September, 1997 until she handed over the case to Ms Leyshon, in February, 1999.²³
- 5.23 As reported in the Commission's Second Substantive Interim Report, Ms Jones had very limited direct interaction with Grace and Family X over this period. The evidence was that Ms Jones met Grace on two occasions. The first was on 20th January, 1999 and the second was on 19th March, 1999, when she accompanied Ms Leyshon on a visit to Family X at the time when Ms Leyshon was taking over as Grace's key worker.
- 5.24 As reported in Chapter 10 of the Second Substantive Interim Report, Ms Jones became focused on Grace's circumstances when she was about to hand over responsibility for her to Ms Leyshon.
- 5.25 As referred to above, Ms Jones said that, when she was handing over Grace's case, she believed that Grace came "*close to the line of needing extra care in terms of hygiene, in terms of stimulation, in terms of meeting more people, do you know, because she used [to] come home and she would be there in the house and like if she was somewhere else there might be more going on and they hadn't been taking up any of the respite care, she didn't go on any of [the] holidays, as far as I can recall.*"

²³ Reported upon in the Second Substantive Interim Report.

- 5.26 In essence, Ms Jones told the Commission that it was her opinion that, at this point, Grace should be moved from Mr. and Mrs. X's care. She said that, from the very start, given Grace's age, she was concerned that Grace was not broadening her social outings or experiences.
- 5.27 In her evidence, Ms Jones said that it was the issue with Grace's teeth, in particular, that she was focused on, when referring to the "*hygiene*" issue. She said that she knew that Grace had sore throats but only realised when she visited the placement that the sore throat was related to Grace's gum disease. She said that she was aware of a concern in relation to Grace's oral hygiene and felt that gum disease might have been addressed through better oral hygiene.
- 5.28 Ms. Jones told the Commission that Grace "*appeared healthy*" and that "*there wasn't a concern about that*".
- 5.29 Ms Jones told the Commission that, from 1995 onwards, Mr. M had told her of occasions when Grace was out sick from Day Service Provider A and that, on one occasion in January, 1999, she had been told that Grace was absent for nearly a month. As reported in the Second Substantive Interim Report, Ms Jones told the Commission that she was "*kind of concerned about it*" and agreed to call out to Mrs. and Mr. X to check it out. The issue of Grace's absences from her day placement is reported at Section 8 below.

Ms Dianne Leyshon

- 5.30 Ms Dianne Leyshon took up her shared role as SEHB Social Worker for Adults with Intellectual Disabilities in February, 1999, replacing Ms Jones. In that role, she worked with young adults with mild, moderate and severe learning disabilities in the community, as distinct from residential settings.²⁴
- 5.31 Ms Leyshon's involvement in Grace's case was from March, 1999 to May, 2001 and her appointment as key worker for Grace heralded the beginning of a period of significant activity in Grace's case. In the course of her involvement with her case, Ms Leyshon met Grace twice. By the time that Ms Leyshon became involved, Grace was aged 20, Mrs. X was aged 63, and Mr. X was aged 77.

²⁴ Reported upon in Chapter 10 of the Second Substantive Interim Report at paragraph 6.22.

- 5.32 With respect to Grace's care needs, Ms Leyshon recalled that there was a view at the time that Grace's placement was "*unsuitable*" in the long term.
- 5.33 As regards Grace's presentation, Ms Leyshon told the Commission that, at the time of her first visit in March, 1999, she thought that, "*there was nothing untoward, you know, that I would have picked out and said, well, she didn't look well cared for or anything*". Ms Leyshon said that Grace was dressed adequately and that her hair was combed and clean. She recalled that Grace was "*slight in stature*" and sat "*twiddling keys*" during her visit.
- 5.34 On her second visit, on 30th September, 1999, Ms Leyshon recorded that Grace appeared well. She noted that Grace's hair was nicely plaited and that she was dressed adequately and looked clean. Ms Leyshon described Grace as being very slight in stature with fair hair, blue eyes and a fair complexion. There was nothing else that struck Ms Leyshon in relation to Grace's appearance or that gave rise to any concern on this occasion. Ms Leyshon told the Commission that it appeared to her that Grace was cared for adequately by Family X at that time. Ms Leyshon also said that she gleaned from her contact with Day Service Provider A at the time that Grace's care was satisfactory for the most part.

Ms Eileen Griffin

- 5.35 In or around 2007, Ms Eileen Griffin, also a social worker, moved to the Disability Services team within the SEHB and became the Liaison Social Worker. Her role entailed case management of adults with intellectual disabilities.²⁵
- 5.36 Ms Griffin saw Grace on two occasions when she visited the home of Mrs. X with Mr. Smith. These visits took place in September, 2007 and June, 2008. With regard to Grace's appearance in 2007, Ms Griffin said that her impression was that Grace's clothes were tight, old and inappropriate. She referred to Grace as "*unkempt*" and said that her teeth were "*decayed*". At the Commission, Ms Griffin described Grace's presentation as evidencing "*unintentional neglect*". Mrs. X, according to Ms Griffin, also looked quite dishevelled.

²⁵ Further detail can be found at Chapter 1 of Volume 1.

- 5.37 Mrs. X had a memory of this first visit from Mr. Smith and Ms Griffin. She recalled during her evidence that, after meeting Grace for the first time, Ms Griffin had said to her that Grace was “a credit” to her and that she thanked Ms Griffin for this. Ms Griffin did not recall saying this and did not think she would have said it; however, she told the Commission that she had no recollection of that conversation. Given the plan that Mr. Smith described during his evidence whereby he and Ms Griffin had agreed that Mr. Smith would be more stern and officious while Ms Griffin would be more sympathetic towards Mrs. X, the Commission does not rule out that a comment to this effect was made by Ms Griffin at the time. These home visits are reported in detail in Chapters 1 and 4 of Volume 1 in the context of the management of Grace’s case by the HSE.

Mr. Iain Smith

- 5.38 The Commission also heard evidence with respect to Grace’s appearance and presentation from Mr. Iain Smith, who became involved in Grace’s case from July, 2007. His and Ms Griffin’s involvement in Grace’s case has been reported upon more extensively in Volume 1 of the Commission’s Final Substantive Report.
- 5.39 In mid-May, 2007, Mr. Smith moved into Disability Services as Social Work Team Leader for People with Disabilities, Waterford Community Services, which was a specialist post working with vulnerable adults with an intellectual disability.
- 5.40 As part of that role, Mr. Smith conducted a review of Grace’s file and produced a document outlining the results of his review, dated 15th August, 2007. With regard to the specific question of Grace’s presentation, Mr. Smith recorded in that document as follows:

“In 1995 the foster parents reluctantly agreed to [Grace’s] attending [the local voluntary association’s] day services. Initially there were concerns regarding [Grace’s] presentation, but it also appears that these lessened considerably over time.”

- 5.41 In a note dated 22nd August, 2007, Mr. Smith documented the details of a meeting that he and Ms Griffin had with Mr. M at Day Service Provider A in relation to Grace and noted that, based on what Mr. M had told him, “[Grace’s] presentation causes no concerns.”

- 5.42 Subsequently, in a note of his first planned home visit to Grace (alongside Ms Griffin) at the home of Mrs. X on 13th September, 2007 (referred to above), Mr. Smith recorded that, in terms of Grace's presentation, she was "*very plainly dressed*" and that he "*found it hard to believe that over €100 [per week] could be spent on her clothes...*".
- 5.43 Regarding this statement in his note of the home visit, Mr. Smith said during his evidence that "*I think what I put in the note was I didn't think that [as] much money was being spent on the clothes as Mrs. [X] said.*" Unlike Ms Griffin, he did not recall observing Grace's clothes being tight or inappropriate for her age or thinking that her clothes appeared old or unkempt. Mr. Smith also did not recall observing during the home visit that Grace had decayed teeth, as Ms Griffin said that she had done when she gave evidence to the Commission.
- 5.44 Subsequently, in Mr. Smith's draft social work report dated 10th January, 2008 (revised in March, 2008), he recorded with regard to the issue of Grace's presentation and the use of her Disability Allowance, in particular, that "[w]e found [Grace] to be very plainly dressed and it was hard to see how [Mrs. X] could spend €155 per week on clothes..."²⁶ Mr. Smith also recorded in his draft report that "*when [Grace] first presented to [Day Service Provider A]...that she had bruising on her body and on one occasion a black eye.*" Mr. Smith noted in his report, however, that "*[t]here is no evidence of neglect at the time of writing, however, on rereading the file it is clear that we will need to check to see that [Grace] has had her difficulties with her teeth and her eyes followed up regularly by Mrs. [X].*" Mr. Smith further noted that: "*[w]hen [Grace] is in [Day Service Provider A] there is nothing remarkable about her presentation*" and he recommended "*further assessment*" in relation to her eyes, hearing and dental care.
- 5.45 Mr. Smith told the Commission that his main concern, as at January, 2008, when he prepared his initial draft social work report, was that "*[Grace] was a very vulnerable person and that it was an inappropriate placement, she was very vulnerable and there were concerns, outstanding concerns as I have said, of abuse and possibly neglect.*"

²⁶ See the section of Mr. Smith's 2008 draft social work report headed "*Financial Exploitation*".

- 5.46 As already mentioned, Mr. Smith went on to prepare a revised version of his draft social work report, dated 7th March, 2008. The extracts referred to above were not amended in the revised report.
- 5.47 In Mr. Smith's note of a meeting with Ms D on 17th June, 2008 regarding Grace's presentation at Day Service Provider A, a meeting which he described in his evidence as an attempt to get an update on Grace, he recorded that Ms D told him that "[Grace] *was very thin. 'She has the body of a child.'*" Mr. Smith went on to record that Ms D said that Grace had been weighed that day and "*came in at 6 stone and ten [pounds]. We estimated [Grace] at five foot three which would leave her underweight in terms of body mass index. [Ms D] said that [Grace] was a good eater at lunch. She wondered if [Grace's] weight would change through regular attendance and she said that she would keep records of this.*" This evidence is more fully considered by the Commission below in Section 6, dealing with Grace's weight.
- 5.48 Mr. Smith did not refer to Grace's presentation or appearance in his note of his and Ms Griffin's second home visit to see Grace and Mrs. X, on 23rd June 2008.
- 5.49 On 20th August 2008, Grace was taken to hospital having presented at Day Service Provider A with a "*yellow bruise under her right eye*" which was fading, as well as "*two small scabs on the edge of the bruise*". On that occasion, Mr. Smith noted that "[Grace] *also had a lot of small sores around the back of her neck and behind her ears. [Grace's] hair looked unkempt. It was very long, in poor condition, with lots of small white flakes in it and tied together with an elastic band*". He also noted "[b]ruising/ x ray finger – old fracture... [Grace's] *neglectful appearance – Home – [observations] re arrival*". The events of 20th August, 2008 are reported upon in detail in Chapter 7 of Volume 1 and in Chapter 2 of this Volume.
- 5.50 Mr. Smith said during his evidence that he could not remember any more about this than what he had recorded, adding that it was "*only the note that is triggering what I am remembering.*"
- 5.51 In her evidence to the Commission, Mrs. X recalled Ms D's telephoning her at 4 p.m. to tell her that Grace would not be home on the bus and "[n]ot to worry, that she noticed that [Grace] *had spots, I don't know where now*". Mrs. X said that when she asked Ms D if she knew how Grace came to have these spots, Ms D said that she did not know and that she was "*not to worry, she'd bring her back.*"

- 5.52 In a note prepared a number of weeks later by the staff of Day Service Provider A, on 11th September, 2008, it was recorded that “*there are little red bumps on the back of [Grace’s] neck just under the hairline.*” Mrs. X did not remember this being brought to her attention at the time but she said that “[Grace] *always had spots*”.
- 5.53 In her note of the events of 20th August, 2008, Ms B recorded that she spoke to Mr. Smith that day about Grace’s “*Personal hygiene*” and told him that Grace had “*generally poor hygiene, often a noticeable smell and today when scrunchie had to be removed for x-ray, [social worker] noted that hair was quite greasy and matted together as a result. Ends of hair tied together with blue elastic band.*” Ms B also recorded that, despite being in receipt of Disability Allowance, Grace had “*very few items of new clothing.*”
- 5.54 While Mr. Smith said in evidence that he considered what Ms B had told him about Grace’s having very few items of new clothing as “*significant*”, and as raising a query as to neglect, he added that it was “*not the most important thing because...I’m not making out a case here against [Family X] on grounds of abuse and neglect. The question for me was this was an inappropriate place for [Grace] to be living.*”
- 5.55 With regard to Ms B’s note of having informed Mr. Smith that “[Grace] *has generally poor hygiene, often a noticeable smell*”, Mr. Smith told the Commission that if he was in fact given that information on the night of 20th August, 2008 (which he could not recall), it would have been “*significant in terms of evidence of neglect.*”
- 5.56 In the minutes of the VAC meeting held on 26th August, 2008, following Grace’s attendance at hospital, it was noted that “[Mr. Smith] *felt that [Grace] presented as quite unkempt*” and also that her “[t]eeth and hair appear poor.”
- 5.57 Regarding Grace’s clothing, in his note of his attendance with Grace at the Sexually Transmitted Infections Clinic on 25th May, 2009 (as a follow up to her attendance at the Sexual Assault Treatment Unit of Waterford Regional Hospital on 27th March, 2009),²⁷ Mr. Smith recorded: “*I picked up [Grace] at [Day Service Provider A] and went with [Ms D]. [Grace] was wearing new clothes and [Ms D] said that they belonged to [Day Service Provider A] as [Grace’s] own clothes were not smart*

²⁷ This matter is reported upon in Chapter 14 of Volume 1 and in Chapter 4 of this Volume.

enough for her to be out in. [Grace] appeared to me to have gained a little weight, [Ms D] said she would check."

- 5.58 Ms D did not remember saying anything to Mr. Smith about the need to change Grace's clothes but she said that it was likely that she had made such a comment about why Grace's clothes had been changed.
- 5.59 On 22nd April, 2009, Mr. Smith provided an update to his 2008 draft social work report on Grace.²⁸ With regard to Grace's general care, Mr. Smith reported that there were *"growing concerns over [Grace's] general appearance including her low weight, old clothes, and untreated dental problems."*²⁹
- 5.60 In his later evidence, regarding the part of his 2008 draft social work report to the effect that *"[t]here is no evidence of neglect at the time of writing"*, Mr. Smith told the Commission that, by August, 2009, he thought that *"quite a bit [had] changed in relation to neglect"*. He referred to *"something that was identified by [Ms] Burke [Grace's independent advocate] and that she wrote to [Ms B], that they were seeing these signs of neglect."* Ms Burke's evidence with respect to Grace's presentation is considered below.
- 5.61 Referring to the period following Grace's attendance at hospital on 27th March, 2009, Mr. Smith said that *"[t]here were discussions that I had with [Ms B] about [Grace] at the time, that her clothing was bad, her hair was bad. We had seen a lot more of [Grace] at the times we had admitted her to hospital...So there was a growing picture of neglect."* Referring to Grace's case as one of *"long-term neglect"*, Mr. Smith told the Commission that *"[i]t is a case where I can't see at any time that [Grace's] needs were being adequately met, she didn't have her own bed to sleep in, her own bedroom; as far as I could see she didn't have appropriate clothing."* Grace's sleeping arrangements are reported upon in Chapter 4 of this Volume.
- 5.62 Mr. Smith remained involved in Grace's case subsequent to Grace's move from the home of Family X on 17th July, 2009.

²⁸ In his letter dated 22nd April, 2009, which he sent to Mr. Pat Walsh, Acting General Manager, Waterford Community Care, Mr. Smith wrote that he *"enclosed"* an update to his original report dated 7th March, 2008. However, the report update appeared in the body of the letter to Mr. Walsh and did not take the form of a separate enclosure. The letter was date-stamped as having been received by the General Manager's office on 23rd April, 2009.

²⁹ Reported upon at Chapter 15 of Volume 1.

2009 - Independent Advocate's evidence

5.63 Ms Caroline Burke worked as an independent advocate for two years with Waterford Independent Advocacy, which was a pilot project funded through the Citizens Information Board. During her time working with Waterford Independent Advocacy, Ms Burke facilitated a weekly self-advocacy group at Day Service Provider A and attended PCP meetings in relation to Grace.

5.64 Ms Burke met Grace in Day Service Provider A in the first half of 2009. She set out her views about Grace's presentation in a letter to Ms B dated 13th May, 2009, as follows:

"During these times I have noticed that [Grace's] clothing appears old, tattered, stained and on occasion too small or too big for her frame. I have noticed that her footwear appears too big for her feet, I have noticed that she wears 'LA Gear' trainers, which have not been readily available to purchase since the 90s. I have noticed that there is a particular odour from [Grace] which may be related to poor hygiene. I have also noticed that [Grace's] dental hygiene appears to need a professional consultation as her teeth are yellowing and her gums appear to have a white film over them. I have noticed that there was strong odour from this area also."

5.65 In her evidence at the Commission, Ms Burke said that Grace did not appear at all like she was being looked after.

5.66 Following the PCP meeting of 3rd July 2009, (reported upon above and in Chapter 17 of Volume 1, Ms Burke made further observations in a letter to Ms B dated 10th July, 2009 and highlighted her concerns with respect to Grace's personal care and future planning, stating:

"[Mrs. X] could not name a shop where she buys clothing for [Grace]. [Mrs. X] advised that [Grace] wears a size 2 shoe but that she buys bigger as [Grace] tends to lose balance yet was there a referral made to a specialist in relation to this matter."

In relation to personal hygiene, [Mrs. X] advised that [Grace] is incontinent at night however is not bathed until the next evening, which may account for the odour described in my earlier concerns. [Mrs. X] advised that she will try to bathe [Grace] in the morning...”

- 5.67 Ms Burke went on to observe that “[a]s [Mrs. X], is ag[e]ing I would have concerns about [Grace’s] care placement going forward. What plans have been put in place in the event that something happens to [Mrs. X]?”

September, 1995 to July, 2009 – local voluntary association evidence

Preliminary

- 5.68 The most significant change that occurred in Grace’s daily life at the age of 16, on the evidence received by the Commission, was that she began to attend a day placement in Waterford City. The circumstances in which this change came about have been reported in Section 5 of Chapter 6 of the First Substantive Interim Report.
- 5.69 The evidence to the Commission clearly established that Day Service Provider A and its staff had, by some considerable measure, far more contact with Grace over this period than any official of the SEHB/HSE.
- 5.70 The Commission had valuable evidence from Mr. M, the manager of Day Service Provider A from 1987 to 2008,³⁰ and the care and programme assistants who worked there for varying periods of time between September, 1995 and July, 2009.
- 5.71 Nurse N (deceased), who worked in Day Service Provider A from 1994 to 2000, had considerable contact with Grace and communication by notes and by telephone with Mrs. X over that period. The Commission had the assistance of some notes and records of Nurse N’s relating to her involvement with Grace and of Mr. M’s evidence of Nurse N’s role and her substantial work in Day Service Provider A at this time.
- 5.72 The evidence of and notes made by Day Service Provider A personnel referable to Grace from time to time, are also reported throughout the other chapters of this Volume where relevant to the issues considered in those chapters.

³⁰ Mr. M worked as a trained psychiatric nurse with the local voluntary association from 2008 until his retirement in 2014.

- 5.73 Day Service Provider A personnel were in a particularly good position to observe how Grace presented on a day-to-day basis. They encountered Grace in the morning when she came off the bus and were involved in her intimate care, dealing with changes of clothing, showering her, giving her time in the bath, taking her swimming, doing her hair, providing lunches, and taking her on trips to cafés and on visits out of the centre.
- 5.74 Evidence received and views expressed by Day Service Provider A staff to the Commission concerning Grace's presentation did not provide a uniform picture of Grace. As observed above, differences in accounts given and differences of emphasis about aspects of Grace's presentation were understandable having regard to the element of subjectivity inevitably brought to bear in such assessments. There were differing emphases on Grace's underlying disabilities, her own capabilities, and on aspects of her personality. For example, Grace was portrayed by some witnesses at times as a very quiet person yet by others as very active, at times boisterous, and always on the move. Further, there were differing views offered about the demands associated with Grace's day-to-day care, or when considering reasons for her physical presentation and her behaviours.

The evidence of local voluntary association personnel

Mr. M

- 5.75 Mr. M displayed a realistic but positive view of the capabilities of Grace and saw the day service as an opportunity to expand her world in whatever ways were available through its work. The Commission is satisfied that Mr. M brought an ethos that focused on what could be done for service users, rather than on perceived "deficits" in their capabilities. Mr. M took a positive and proactive approach to how Grace could benefit from her day placement. The emphasis was on the clients of Day Service Provider A going out into the community on a regular basis to participate in activities. This approach was generally echoed in the evidence given by care staff in the day centre.

Mr. M's report on Grace - April, 1996

- 5.76 The first documented view of how Grace presented in Day Service Provider A was set out in the report of Mr. M of April, 1996. This was a progress report on Grace's

first seven months in Day Service Provider A. The report is set out hereunder for ease of reference:³¹

"[Grace] commenced at [Day Service Provider A] on 4th September, 1995. To our knowledge she had not been part of any service prior to this date.

Her first few weeks at the centre were absolutely chaotic. It was evidently apparent that she was untrained to cope and socialise with our group of trainees. [Grace] lacked the social skills to integrate herself into our sheltered setting.

The first four weeks were totally given over to containment. She was unhappy with her new surroundings and made that evidently clear to everyone. From the moment she got off the bus at 10.15 in the morning, until she left at 15.00hrs, she had to be under constant supervision from one staff member. Doors had to be locked or otherwise she would abscond. She repeatedly screamed and shouted non-stop during these initial days. She was almost 'hyena-like' with her giggling and laughing at times. Throughout this time she also continuously soiled herself.

When first introduced to the dining room, she would 'wolf' down her dinner and then steal the dinners of others around her.

From the outset she took to 'head-butting' other trainees both in the centre and on route to the centre aboard the bus. This behaviour proved alarming for the ambulance drivers because she was hurting other clients.

[Grace] always carried a bunch of coloured keys - as a pacifier. But when her foster parents were notified, by the drivers, of her behaviour on the bus, the keys were withdrawn as a form of punishment. This action made the situation more intolerable for us - her outbursts and behaviour got exceedingly worse. At this juncture, [Grace] took to

³¹Mr. M's report is also considered in the Commission's First Substantive Interim Report at paragraph 7.5 of Chapter 6 and

stripping off all her clothes both on the bus and at [Day Service Provider A]. When this happened, the pacifier was returned.

Now after seven months of constant supervision and care, the situation is gradually improving. [Grace] no longer presents with so many problem[s]. Doors remain open and there is no threat of [Grace's] running away. Head-butting, screaming, stripping off, all these behaviours are no longer manifested.

[Grace] loves walking - she would go for miles at an incredible pace. She attends the bowling alley and [to a waterpark in a nearby town]. On these occasions she presents no great problem. [Grace] goes to the park to use the swings and slides - these she loves. The multi-sensory room exerts an unbelievable calming effect on her. Also as an aid to calming her down - she loves having her hair brushed. Her behaviour in the dining-room has reached acceptable levels. No bad behaviour has been reported from the ambulance drivers. She loves going out in our mini-bus for outings - on these occasions she behaves impeccably.

[Grace] is in good health, has been absent only occasionally with the 'flu. She has a great appetite. She has glasses but doesn't wear them always - her eyesight was last tested in the Regional Hospital on 16/11/95. Her hearing, according to foster parents, has been checked at the Hospital also. Her speech is nil. Her self-help skills are minimal - she feeds, dresses and toilets herself. Periods are regular. Her personal hygiene and clothes were at acceptable levels.

[Grace] was on no medication with us. On several occasions when she was being bathed at our centre, bruising was noticeable on her body. These bruises were brought to the attention of the foster parents, they informed us that they couldn't account for these bruises and said they must have happened when she was on the bus.

The foster parents communicated with us by letter rather than by 'phone. We had a very good relationship with [Mr. & Mrs. X].

Overall [Grace] has made remarkable improvements. Gone are the days of containment. We have progressed to the stage of introducing her to outside activities like swimming and bowling. These have been successful to date. She also goes on a daily walk. She now presents no problems to other trainees.

Obviously after confinement at home, she was unaccustomed to dealing with an environment like ours. She now appears more happy and content in herself."

5.77 In his evidence to the Commission, Mr. M said he could not think of anything in Grace's presentation that gave him cause for concern over this period. Indeed, Mr. M's evidence with respect to Grace was to the effect that he never thought that there was anything relating to her presentation that gave him cause for concern about her care from the perspective of neglect or mistreatment.

5.78 As already reported in the First Substantive Interim Report, the Commission is satisfied that Grace's behaviour over the initial period of her attendance at Day Service Provider A, as outlined by Mr. M in his above report, was attributable to the impact of this change in her day-to-day circumstances at this time.³²

Mr. M's evidence with respect to Grace's clothing

5.79 In his evidence on Grace's appearance and presentation over the years that he knew her, Mr. M agreed that he "*wasn't ever critical of the manner in which she was dressed*", adding "*I can't say she was really badly dressed*".

5.80 By way of context, Mr. M told the Commission that;

"[i]n those days particularly for the males the uniform of choice was tracksuits...and so you could have ten or more guys wearing tracksuits and I didn't question it because you're saying well this is what the

parents can afford. There is rough and tumble in here. It's going to be football and this and that. We're not going to send them in in their best."

5.81 In this regard, Mr. M said that "[e]qually with the girls that some of them did present in tracksuits and [Grace] came in with trousers, top."

5.82 Mr. M also highlighted some practical considerations with respect to choice of clothes for service users, as follows:

"Like I'm sure, 40 per cent or more of the clients, the parents would have decided what was going to be worn on the day and they'd put them out on the day. Some of them would have been able to dress themselves totally, but in [Grace's] case, no, you would have to tell her the order of which goes which and where and you would have to do up the buttons or zips or...fasteners"

5.83 Mr. M said that he did not *"form opinions on the way people were dressed"*. He said that people came for activities that involved physical education and artwork and they could return home in the evening *"destroyed"* with paint and sweat from playing games. He said that he did not expect the service users who came to the centre to come in *"suited and looking well"*.

5.84 Mr. M felt that Grace's clothes were suitable for the kind of activities she was doing, saying in his evidence that *"she [was] going to be out in the garden, she was going to be on the bike, she was going to be on the swings, you know she wasn't going to be coming in dressed immaculately."*

5.85 Mr. M gave a specific instance of Grace's clothes that had been packed by Mrs. X for the one annual holiday that Grace went on with Day Service Provider A. Mr. M could not remember if the clothes were old or not, but he said that Grace was dressed *"appropriately"* for this occasion.

5.86 In his evidence, Mr. M emphasised that:

³² The impact of Grace's commencing her attendance at Day Service Provider A is reported upon in detail in Chapter 6 of the Commission's First Substantive Interim Report: see, in particular, paragraphs 5.31 to 5.34, 8.1, and 8.30 to 8.42 thereof.

"It wasn't as if [Grace] was coming in in rags or, you know, we were embarrassed by, like, as I said, I brought the girl out into community myself quite a lot...And it's not as if we said, 'oh, [she's] not wearing the right attire here, let's change her because we are going to...present ourselves in the community', that didn't happen".

- 5.87 On the issue of how Grace's clothes compared with those of other service users, Mr. M remarked that *"when we come to the area of dress and appearance we are entering into a very subjective world."* His observations on this aspect provided context as follows:

"Comparison is always a difficult thing because you don't know what the financial state of any family was... those guys now were guys who were earning a few extra quid in the work that I had found them...[T]hey could have had three changes in their bag, they were wearing clothes coming into work, they were changing into their uniform, which they loved, to go to work and then they could go to their locker and they could have their football gear, their hockey gear, whatever it was, and after those events they would be showering. To compare those kind of people to [Grace] wouldn't be right..."

- 5.88 Mr. M agreed that Grace's clothes could be described as old-fashioned, but he said that the imperative for Day Service Provider A was to ensure that, no matter what service users wore when they arrived for the day, they were warm during winter and cool during summer. If Grace came to Day Service Provider A without a coat, he said, they would find her one if she was taken out, adding that they were constantly looking for coats for people. Grace did not have all of those things, but others did not have them either. In the course of his evidence, Mr. M said that *"her clothes did appear to come from the '50s or '60s, but we had a few hippies working on the staff who were worse dressed. So [Grace's] presentation didn't cause me any concern."*
- 5.89 Mr. M did not recall a smell coming from Grace's clothes, his recollection being that her clothes were clean. Reflecting on this at the Commission, Mr. M said: *"I sat with the girl at the table, I couldn't say that I was conscious of an overpowering odour, either body odour or dirty clothes."*

- 5.90 In this regard, Mr. M did not agree with evidence from some of the other staff at Day Service Provider A, referred to below, that Grace could be described as coming into the centre dishevelled or unkempt. Reflecting on some of the evidence given by other staff, Mr. M said that, in his own view, Grace's clothes were never an issue, describing them as "*sufficient unto the day*". In this regard, Mr. M said: "*I suppose we all would have loved to have got her different clothes, there is no doubt about that, but they were sufficient for what she was going to be doing*".

Mr. M's evidence with respect to Grace's incontinence and toileting

- 5.91 The particular challenges that arose in managing Grace's incontinence in the context of her care and her unaccompanied travel by bus to and from Day Service Provider A are mentioned at paragraph 3.39 above and are also reported in Chapter 2 of this Volume.
- 5.92 It was well established in the evidence considered by the Commission that this issue of incontinence had an impact on Grace's appearance and presentation. The occurrence of Grace's wetting or soiling herself on the bus or during the day was not an infrequent one. Grace regularly needed to have a shower on arrival in Day Service Provider A as a result and she sometimes also needed a change of clothes.
- 5.93 Mr. M gave evidence that, at one stage, Mrs. X, in trying to deal with the problem, decided to put incontinence wear on Grace prior to her getting on the bus and asked that, when Grace arrived, Nurse N remove the incontinence wear and put her underclothes back on. Mr. M told the Commission that this was done in Grace's best interests and that Mrs. X. was trying to be helpful. He said that Mrs. X was trying to assist Nurse N and *vice versa*. This is a matter reported upon in Chapter 2 of this Volume.
- 5.94 Mr. M recalled that "*unfortunately*", when Grace happened to have an episode of incontinence, the staff at Day Service Provider A had to dress her in clothes that belonged to the centre. He gave evidence of how, rather than sending Grace's soiled clothes home on the bus with her, her clothing was laundered at Day Service Provider A overnight and dried in the morning. Mr. M described how Mrs. X sent in clean underwear but that Grace's outer clothes got soiled as well. Mr. M recalled that it caused some agitation to Mrs. X to see Grace dressed in clothes that were not her own. Some of the telephone contact between Mrs. X and Day Service Provider A

was, he said, related to practical matters such as arranging for spare clothes for Grace.

- 5.95 Mr. M gave evidence that Mrs. X asked that Grace not be dressed in clothes that were not her own and that the staff tried to explain that they had no other option because she did not have a spare set of clothes. Commenting on this, Mr. M told the Commission that Family X was not the only family that felt that way. Mr. M said that Mrs. X washed and returned the clothes that had been loaned to Grace by Day Service Provider A in such situations.

Mr. M's evidence concerning Grace's hair

- 5.96 Mr. M told the Commission that they had discussions at Day Service Provider A about Grace's hair, which, he said, was very thick and *"needed a lot of combing, it needed a lot of attention, and that we did"*.

- 5.97 Mr. M said that in his first meeting with Mrs. X, she told him about what Grace liked. He said that:

"[Mrs. X] told us things like [Grace] loved getting her hair... brushed... which she did, she wouldn't let you stop when you were brushing her hair, you just had to keep going. She had long, long hair and I suppose the massaging effect she loved it. It would have happened every day to calm her down that you would have brushed her hair. We would have talked about things like that, the fact that she liked showering."

- 5.98 In his report in April, 1996, referred to above, Mr. M noted that *"[t]he multi-sensory room exerts an unbelievable calming effect on [Grace]. Also as an aid to calming her down - she loves having her hair brushed"*.

- 5.99 Mr. M said that the staff knew that if Grace was agitated, the instant solution in order to calm her down was to do the things that she loved the most, which meant the bath or brushing her hair. With reference to evidence from CW4 on the topic of Grace's hair (reported on below), Mr. M did not agree that the only time that Grace's hair was only neatly tied back was when it was done by Day Service Provider A staff. Commenting on evidence from other staff members to the effect that Grace was

dishevelled and that her hair was in poor condition, Mr. M said that, although it was not to say that this never happened, he expressed a concern at the Commission as to whether this was “*reading backwards*”.

- 5.100 In this regard, Mr. M said “*I don’t know because I didn’t find anything offensive in [Grace]. Sure, I would have loved to have seen [her hair] more modern, updated, and they’d spent a lot of time on her hair in [Day Service Provider A]*”.

Correspondence between Mrs. X and Day Service Provider A about Grace’s hair

- 5.101 There was occasional correspondence between Mrs. X and Day Service Provider A regarding Grace’s hair.

- 5.102 An undated handwritten note from Mrs. X to Nurse N expressed thanks for “*letting us know about the hairdresser*” and went on to say that they would “*leave it this time*” because “*[w]e wanted to grow [Grace’s] hair a little longer...*”

- 5.103 A further handwritten note from Mrs. X to Nurse N, written some time between 1995 and 2000, stated:

“I need your help regarding [Grace’s] hair. Every morning I send her out with her hair plaited and hair bands to keep it in place. When she arrives back home she looks more like a scarecrow, hair all over the place, no bands or clips. Now I am assured this does not happen on the ambulance. Now [Grace] is not able to touch her hair, she can’t even take the bands off so can you throw any light on what’s happening. I am considering having her hair cut short on Wednesday, what do you think. I am not moaning but it is disheartening when this happens – hope you can help. Thanks a lot.”

- 5.104 Another undated handwritten note from Mrs. X to Nurse N stated: “*Very many thanks for your most welcome letter. Now we know the explanation for the condition of [Grace’s] hair we certainly have no complaint and we are very happy. Thanks again.*”

CW2

- 5.105 CW2 was the care staff member in Day Service Provider A who had the most experience of working with Grace over the period of nearly 14 years of Grace's attendance there while resident with Family X. CW2 began working at Day Service Provider A in 1997 and was still employed there at the time Grace was moved from Family X into residential care in July, 2009. CW2 continued to be employed at Day Service Provider A at the time she gave evidence to the Commission.
- 5.106 CW2 had finished a one year pre-nursing course and a six month FÁS course before starting work at Day Service Provider A. She continued working at Day Service Provider A the following year under the Community Employment Scheme. In 1999 she took up a position as Programme Assistant, reporting to CW1. CW2 told the Commission that her role in Day Service Provider A involved helping the service users with their day-to-day needs, as well as assisting service users out in the community.
- 5.107 CW2 said that she did not receive training before commencing work in Day Service Provider A but that she learnt on the job and from her supervisors. CW2 told the Commission that Mr. M would give talks to the staff every few months on various topics such as epilepsy or challenging behaviour.

CW2's evidence regarding daily reports and body charts

- 5.108 As regards the systems in use in Day Service Provider A, CW2 said that the care assistants had to complete daily reports and body charts if they happened to notice a mark on any service user. The purpose of the daily reports was to record what the service users did in the mornings and afternoons and what their mood was like on any particular day. As well as completing the daily reports and body charts, CW2 said that care assistants informed their supervisor or Mr. M whenever they noticed a mark on a service user. CW2 recalled how, in her early days in Day Service Provider A, she was told to watch out for marks and bruises on Grace and to report them to a supervisor. She said that she was aware that Grace tended to scratch her face, her arms, her legs, and her back. This habit of Grace's is reported upon in Chapter 2 of this Volume.

CW2's evidence with regard to service users with severe disability

5.109 CW2 said that her preference was to work with service users in the severe category of disability and that she quite often worked in what was called the severe category room. She explained that, *"the way [Day Service Provider A] was set up at the time was that there were three rooms: there was mild, moderate, and severe, so [Grace] was placed in the severe room and if I was in the severe room then I would have an awful lot of contact with her."* CW2 recalled how three or four of the FÁS placement staff together with a supervisor worked alongside six or seven service users in the severe category room because of the particular challenges of managing and caring for this group.

CW2's evidence regarding Grace's clothing

5.110 As regards Grace's presentation, CW2 told the Commission that, when she first met Grace, she thought that she *"stood out"* and that she was different from the other service users in terms of her clothing and hair. CW2 said that Grace wore old-fashioned clothes and that her jumpers were like *"something from the '80s"* (it was the late 1990s by then) and looked wrong on someone her age. She said that the rest of the service users appeared well cared for; they had clothes that were fashionable at the time, but that Grace did not.

5.111 CW2 said Grace's clothes were sometimes dirty and, less often, stained. She could not recall precisely, but she thought that the staff at Day Service Provider A had to change or freshen Grace up maybe two or three times a week but sometimes less often than that. CW2 said that Grace's undergarments were not always clean and that sometimes her outer garments were dirty and stained, which gave the staff cause for concern. CW2 said that, when she was in close contact with someone, as she was when she was providing care, she knew whether their undergarments, such as vests and socks, were clean or dirty and if they had not been changed for a day or two. This, she said, was a relatively regular occurrence for Grace, occurring perhaps once or twice a week. However, CW2 said that there were also periods when there were no problems in that regard.

5.112 CW2 recalled that, on one occasion, Mrs. X telephoned Day Service Provider A and told Mr. M or one of the supervisors never again to put clothes on Grace that were

not her own, following which Mrs. X returned the clothing in question to Day Service Provider A.

5.113 CW2 said that they asked Mr. M for money to buy clothes for Grace. She could not recall how often that was done and it was also not clear from the evidence as to whether this was done on more than one occasion.

5.114 CW2 did not remember having raised any issues with respect to Grace's presentation or appearance with her supervisors. CW2 also referred to the fact that, at the time, she herself was a 19 year old girl who had just left school and said "[s]o if I had any concerns I would have probably kept them to myself or then maybe mentioned it to my supervisors and said 'what's going on here?' I would have taken my direction from them".

5.115 There were no records or notes in the daily records with respect to Grace of CW2's having raised any issues about her presentation in Day Service Provider A. However, the Commission accepts CW2's recollection of asking to have clothes bought for Grace at some stage during the period the subject of this Chapter.

5.116 CW2 did not agree with the positive description of Grace's appearance in a further report prepared by Mr. M in November, 2000. This was a report prepared by Mr. M at the request of the SEHB, which was to be sent to Grace's mother at a time when a letter of "consent" was being sought from her for Grace to take up a residential placement in Residential Facility A. This report and the management of Grace's case over that time have been reported in detail in Chapter 10 of the Commission's Second Substantive Interim Report.³³

5.117 CW2 said that Mr. M's 2000 report was, at times, inaccurate, in that Mr. M described Grace as somebody who was well cared for and neat. CW2 did not agree that this was always the case, her evidence being that Grace's clothes were sometimes dirty and that her hair was sometimes matted and unbrushed. CW2 said that Grace's hair would be in such a condition perhaps twice a week. It might then be brushed for two to three weeks, after which, she said, they would "*go back to square one*". CW2 said that Grace's hair was greasy and unkempt and tied up in either a ponytail or a plait.

³³ At paragraphs 11.34 to 11.47.

She said that, in the summertime, Grace would scratch her hair because of the heat and that they wanted to cut her hair but were not allowed to.

- 5.118 Regarding her impression of Grace, CW2 said that she was *“intelligent even if she was non-verbal. She was quite social. She loved music”*.

CW2’s evidence concerning Grace’s incontinence and toileting

- 5.119 CW2 also described how Grace required a lot of personal care due to the fact that she frequently suffered from urinary incontinence at Day Service Provider A. She told the Commission about how the staff brought Grace to the toilet frequently in order to avoid episodes of incontinence but that, unfortunately, she sometimes wet herself.
- 5.120 CW2 told the Commission that Mrs. X said that Grace was not incontinent at home during the day and that she only wore incontinence wear at night-time. CW2 said that Mrs. X was adamant that Grace should not be wetting herself in Day Service Provider A and that she did not like it when it happened. CW2 said that the staff of Day Service Provider A therefore began washing and drying Grace’s clothes on the same day so that Mrs. X would not know about such incidents.
- 5.121 An example of a typical type of engagement between Day Service Provider A and Mrs. X about the matter of Grace’s incontinence can be found in a note made by CW2 on 17th February, 2007. She wrote that *“[Grace] went on the bus today as it was raining. We went to a few shops... When we got back to the [Day Service Provider A] [Grace] went into the toilet. I checked on her + discovered she was soiled. I put clean clothes on her + phoned [Mrs. X] to explain what had happened. She requested that the soiled clothes be returned to her. These went home with [Grace] on the... [bus]”*.
- 5.122 Communications between Day Service Provider A and Mrs. X are reported in Chapter 6 of this Volume, aspects of which are repeated here where relevant to issues of Grace’s presentation in Day Service Provider A. CW2 said that she was afraid to say anything to Mrs. X because she found the relationship quite difficult. Her evidence was that she felt that Mrs. X always telephoned to complain, so she was quite scared to tell Mrs. X if something had happened. CW2 said that anytime she had to telephone Mrs. X, Mrs. X would complain. She said that Mrs. X complained if Grace went home in a different set of clothes, if she soiled herself or was incontinent, if she had a different hair style, if she left an article of clothing

behind her, if it was a sunny day and they had not put her jumper back on her, or if they asked to cut her hair. She said that she had no memory of Mrs. X's ever telephoning to compliment them or to praise them for the work they were doing.

- 5.123 However, CW2 also said that Mrs. X did not complain about the care generally provided by Day Service Provider A and that Mrs. X was quite pleasant at times if they were making small talk. It was when it came to particular matters to do with Grace, as referred to above, that CW2 said that she felt that Mrs. X was quite harsh in her criticism. Whatever about CW2's view of the tone of her communications with Mrs. X, it appears that the purpose of these calls from Mrs. X was to raise concerns of the kind referred to above in the context of her position as Grace's carer.

CW1

- 5.124 CW1 commenced working in Day Service Provider A in September, 1997 as a care assistant. She had completed her Bachelor of Arts Degree in Applied Psychology in University College Cork the previous May. CW1 was subsequently employed as a programme assistant and later as a programme supervisor and, in all, worked at Day Service Provider A for three years. In her role as programme assistant, CW1 was involved in organising activities for the service users and had more responsibility than she had in her role as a care assistant.
- 5.125 CW1 told the Commission that, in or around 1998, a system of incident reporting was introduced at Day Service Provider A. She said that, initially, she thought it was to record daily activities, but that Mr. M clarified that it was to record if a specific incident occurred during the day. After twelve months as programme assistant, CW1 was promoted to the role of programme supervisor, a role she held until 2000. As programme supervisor, she was responsible for the staff and service users in the room she was allocated.
- 5.126 CW1 told the Commission that Grace was very petite and had clothes that were ill-fitting, and not fashionable or new. However, CW1 did not ever remember Grace's clothes being dirty. She remembered them being worn but not to the extent that there were holes in them. CW1 said that she believed Grace's clothes were appropriate for the activities that Grace was doing at Day Service Provider A.

- 5.127 CW1 said that Grace's clothes and her appearance remained the same throughout the period that she worked at Day Service Provider A but that the condition of Grace's teeth and gums got progressively worse over that time.
- 5.128 Describing communication with Grace, CW1 told the Commission that she responded to commands, such as *"go to the toilet"*. CW1 said that she did not agree with Mr. M's rather positive portrayal of Grace's level of independence or her ability to communicate, as set out in his report of November, 2000. She also noted that Grace's self-care was prompted.
- 5.129 CW1 also indicated that she did not agree with the line in Mr. M's 2000 report to the effect that Grace was *"obviously well cared for"*, saying that while other service users arrived to the day centre with new clothes, sports gear or fashionable gear, Grace did not. She said that there were *"other trainees who came in in freshly new bought clothes regularly and we would all talk about their new clothes. [Grace], it is just one aspect of and investment in her, in her personal care, in her personal look, in her skin, in her hair that maybe would indicate, and indicated to me that it would have been nice had she had that...from home...But we would have done it in the [day centre], as in there was times that we would have bought clothes..."*
- 5.130 In that regard, CW1 explained that, from time to time, the staff purchased clothes for the service users (not specifically for Grace).
- 5.131 In terms of bathing, CW1 told the Commission that Grace *"absolutely loved water"* and related how she would get very excited about being in it. She described how Grace was very calm when they put her in the bath and washed and brushed her hair and how, when they brushed and dried her hair after the bath, she would sit very still and be calm. CW1 also described how Grace loved to have her hair plaited, describing it as a lovely activity to do with her.

CW4

- 5.132 CW4 studied Applied Social Studies and Social Care at Waterford Institute of Technology (as it was known then) and, as part of that course, did a year-long placement at Service Provider A, beginning in September, 1996. CW4 said that when she worked at the day centre, a supervisor was present in the room that she worked in but that, mainly, she learnt on the job. CW4 said that she worked alongside five

other people on placement, with Mr. M as the direct line of management while Nurse N played a big part in supervision.

- 5.133 CW4 finished her placement in August or September, 1997 and started her college course. She returned to work in Day Service Provider A in 1999 for a three-month placement through her college course and stayed on after the placement ended as Nurse N was on sick leave. She continued working at Day Service Provider A until just before she commenced a new job in June, 2000.
- 5.134 CW4's recollection was that she worked directly with the service users and spoke to her supervisor or to Mr. M if she wanted to raise any concern regarding a service user, describing it as a "*chain of command*".
- 5.135 CW4 told the Commission that she had no memory of filling out body charts when she worked in Day Service Provider A. She said that she was aware from reading the documentation provided to her by the Commission that she wrote entries on a page with regard to each service user she cared for.
- 5.136 As regards her recollection of Grace, CW4 said that her memory had been jogged by the documents, explaining that she "*really had to think about who [Grace] was...*" She remembered Grace's being dressed in old style clothes, jumpers, and tracksuit pants and agreed with the evidence of CW2 that her clothing was functional. CW4's impression was that Grace's clothes seemed "*worn*" but she said that there were "*no holes or rips or any of that kind of stuff*". She commented that "[e]ven when [Grace's clothes] were washed they were never going to appear nice".
- 5.137 CW4 told the Commission, however, that she could not say that Grace's clothes were a matter of concern for her at the time. She also could not recollect any conversations in Day Service Provider A at the time about Grace's clothes. She could only say, by reference to what she had heard at the Commission about clothes needing to be bought for Grace, that it was something that came up for discussion.
- 5.138 CW4 recalled being involved in Grace's care needs and toileting, as a member of staff working with service users with severe disabilities. She described her role as follows:

“Depending on what room you were, it was toileting if you were in the severe room, it was attending to their toileting needs, you might do some music time with them, you could go off out and do swimming or other activities”.

5.139 CW4 noted in her evidence that incontinence was an issue for Grace. She said that Grace could be soiled when she came off the bus in the mornings and that she might have needed to be washed and changed. She thought that part of the routine in working with Grace was the requirement to bring her to the toilet but she could not recall any further details in relation to this.

5.140 CW4 told the Commission that she remembered a “strong smell” coming from Grace. She said *“sometime[s] that could be urine, all of the time it was a strong smell of saliva because she was constantly dribbling and sucking on the keys.”*

5.141 CW4 told the Commission that the staff in Day Service Provider A played a large role in maintaining Grace’s hair and washing it, saying:

“She had quite kind of fuzzy hair from what I can remember, it was blonde and fuzzy. I suppose when they say that it was matted it was knotty. My recollection is that [Grace’s] hair generally was done when she was in [Day Service Provider A] and that is how it remained until it was done again. That is my recollection of it.

CW5

5.142 CW5 began working in Day Service Provider A as a care assistant in late April / early May, 2004. Prior to taking up employment in Day Service Provider A, CW5 had worked for approximately five years in the L’Arche Community with people with intellectual disabilities and then with the Brothers of Charity for two or three years up until 2001.

5.143 CW5 told the Commission that, in 2004, the care assistants in Day Service Provider A were made key workers to particular service users, with each key worker having seven service users assigned to them. The role of the key worker was to meet the needs of the service users from the time that they came into Day Service Provider A until the time they left and to liaise with the parents if there were any concerns. The

key workers were also responsible for keeping the records and daily schedules for their assigned service users. CW5 finished working in Day Service Provider A in July, 2007.³⁴

5.144 CW5 told the Commission that she did not meet Grace for “*a good few weeks*” after she first started in Day Service Provider A, which she said was due to the fact that Grace was absent from the day centre.

5.145 CW5’s first impression of Grace was that she was very active and pleasant and she recalled that her hair was plaited. CW5 thought that Grace’s clothes were old-fashioned and worn looking. She recalled that Grace liked to be mobile and was “*fairly fast paced*”.

5.146 CW5 was not sure if she ever raised the topic of Grace’s clothing with her supervisors or that it was a matter of concern for her, her recollection being that she thought that Family X might not have had much money.

CW6

5.147 CW6 studied Applied Social Studies and Social Care at what was then known as Waterford Institute of Technology. In 2004, as part of that course, she did a twelve-week placement at Day Service Provider A from March until May of that year.

5.148 In June, 2006, CW6 took up part-time work at Day Service Provider A, which involved providing cover when a staff member was unwell.

5.149 In November, 2007, she interviewed for a full-time position as a care assistant at Day Service Provider A and was successful. CW6 told the Commission that, insofar as body charts were concerned, she was told that, if a service user had any marks, scratches or bruises, they were to be recorded in the body charts.

5.150 CW6 told the Commission that Grace’s clothing was very old and consisted of woollen jumpers which sometimes smelled “*musty*”. She said that Grace sometimes appeared unkempt and that her clothes were too big for her. CW6 indicated, however, that Grace’s clothing did not stop her from taking part in all her activities.

³⁴ CW5 believed that she took maternity leave from Day Service Provider A from January to September, 2005.

She, like a number of the other programme assistants and Mr. M, considered Grace's clothing to be functional.

- 5.151 CW6 met Mrs. X once, at the PCP meeting on 3rd July, 2009. She said that her impression of Mrs. X was that *"she seemed like a nice lady"*, describing her as *"well dressed"*, *"well kept"*, and as having *"very long hair herself"*.

CW7

- 5.152 CW7 completed a course in Social Care in Waterford Institute of Technology in 2007. She commenced working at Day Service Provider A as a programme assistant in February / March, 2008 and continued working there until late 2016.
- 5.153 CW7 told the Commission that she used to write up daily notes for the service users at the end of each day. The purpose of these notes, she said, was to document how the service users got on during the day, what activities they did and what they ate and drank. CW7 told the Commission that if something of concern arose during the day, she would report it to her manager as well as documenting it.
- 5.154 CW7 said that she did not see a lot of Grace when she first started working in Day Service Provider A. She said, however, that Grace's clothes were unkempt, her hair was often *"tossed"* and that, generally, she did not *"present well."* CW7 noticed a smell off both Grace's breath and clothes. During her evidence, CW7 noted that Grace was incontinent *"quite regularly"*, which she had understood was the reason for her clothes being soiled.
- 5.155 CW7 said that Grace's teeth *"weren't very well kept at all"*. She told the Commission that Grace did not tolerate having her teeth brushed very well.
- 5.156 On one occasion, on 4th September, 2008, CW7 made a note that she received a telephone call from Mrs. X, who complained that Grace had been sent home only in a t-shirt and coat. CW7 wrote up a note to say that the reason that Grace had been sent home in that way was because dried faeces had been found on the sleeve of her jumper, which meant that the jumper had been placed in the wash at Day Service Provider A. There was no evidence before the Commission of how this soiling occurred, when it occurred, or whether it had occurred during the course of the day.

There was also no evidence to indicate that this nature of soiling of Grace's clothing happened other than on this occasion that was noted by CW7.

CW8

- 5.157 CW8 commenced work in Day Service Provider A on 13th September, 1996 as part of the Teamwork Scheme with FÁS. In April, 1998, CW8 left Day Service Provider A and took up a permanent position with the local voluntary association's respite service. She returned for a brief period of around two months in 2008 and also provided some relief work. CW8 later moved to the local voluntary association's residential service. All told, CW8 worked at Day Service Provider A for approximately 21 months during the time that Grace was resident with Family X. She continued to work with Grace at the local voluntary association's residential service at the time she gave evidence to the Commission.
- 5.158 CW8 agreed that there was a lot of "*on-the-job training*" in her work at Day Service Provider A and that she learnt by watching others, rather than by any formal induction or training. Her first role within Day Service Provider A was as a personal care assistant. This role involved providing personal care, such as bathing and showering to different service users, going to day activities and outings with them, and assisting with feeding, if required. She said that the role encompassed the full range of needs that a service user might have on any given day.
- 5.159 CW8 could not remember the practice for recording injuries received by service users in 1997 or reporting other matters, but she told the Commission that such matters were reported to the manager. She could not remember reporting anything to management, including anything with respect to Grace.
- 5.160 CW8 told the Commission that Grace was one of the service users that was regularly allocated to her as a personal care assistant. She said that Grace used to come into Day Service Provider A dishevelled and unkempt. She said that while Grace's clothes were not dirty, they were not freshly washed and had a "*musty*" smell. In this regard, she told the Commission that she never remembered Grace's arriving into Day Service Provider A with fresh, clean, new clothes. CW8 said that Grace was "*toileted quite a lot*" and that the staff of Day Service Provider A used to wash her clothes if she was incontinent.

- 5.161 CW8 said that the issue of Grace's clothing caused her to have concerns in relation to her welfare. While she could not remember having a conversation, or staff having a conversation, about Grace's presentation, she added that she was "*sure we did*".
- 5.162 CW8 said that she remembered clothes being purchased for Grace by Day Service Provider A, although she could not remember who bought them, when this was, or who gave the money for them. She said that if they bought clothes for Grace, they would change her into them because of her incontinence. CW8 went on to say that Grace was brought to the toilet quite a lot but that she would sometimes have little "*mishaps*" and would wet or soil herself and need to be changed. She said that she remembered being vaguely aware that Mrs. X did not like Grace's being dressed in clothes that were not her own.
- 5.163 With regard to Grace's hair, CW8 said that it would be "*like it was the day before, like it wasn't brushed*". She described Grace's hair as "*matted, kind of unclean*", while at the same time concurring with CW2's evidence that there were periods when Grace's hair was well attended to. She could not recall whether this was for days or weeks at a time, only the hair "*mostly being dishevelled*."
- 5.164 CW8 recalled attempting to brush Grace's teeth after lunch in Day Service Provider A. Her evidence was that this was a difficult process because Grace's teeth were "*quite sensitive and sore*". CW8's impression was that Grace's teeth were not being brushed at home. She described how, after absences from Day Service Provider A, the staff would have to start the brushing all over again. CW8 said that "[Grace would] *be moving away, like 'what's this toothbrush...coming for her?'*". The evidence heard by the Commission with respect to Grace's teeth is considered separately below in Section 9, relating to Grace's dental health.
- 5.165 The Commission's conclusions with regard to the differing perspectives of Mr. M and members of the day service's care staff with respect to how Grace presented, are set out below in its findings on Grace's presentation.

Ms B

- 5.166 Ms B qualified with a Bachelor's Degree in Social Studies and a social work qualification from a Dublin university in 2007. Almost immediately after graduating, she began working in a medical social work post, where she remained until, in 2008,

she took up the newly created post of social worker with the local voluntary association, working in the field of intellectual disability. This post was taken up by Ms B as a newly qualified social worker. The initial intention was that the holder of the post would carry out respite assessments, but it broadened to include the provision of a social work service in both the association's day service (Day Service Provider A) and residential service, as well as the performance of other roles, such as sitting on admissions committees. Ms B said that, four days a week, she worked in respite services, where there were 200 respite service users who needed assessment. The remainder of her time, one day a week, was spent in Day Service Provider A, providing a social work service to 35 service users.

5.167 Ms B initially reported to the association's Clinical Nurse Manager (Grade 2) in respite services, and later reported to Ms C, the association's Director of Nursing.²

5.168 Ms B first met Grace on 25th June, 2008 as part of her induction spending a day with Ms D in the day service. Ms B said that she was introduced to everybody that day and that [Grace] was *"one of the few"* that she could remember on that first day. In this regard, Ms B recalled *"the very first time [she] set eyes on [Grace]"* as follows:

"I was introduced very briefly and as we walked out of the room I said to [Ms D], you know, something to the effect of: 'What is the situation with that lady?' It was quite apparent, you know, from a neglect point of view, immediately I had concerns and [Ms D] said to me: 'It's okay, that's all in hand. She has a social worker in the HSE, [Mr.] Smith, I've met with him' and that the bed in [the residential unit within the local voluntary association] was earmarked for her."

5.169 Describing her first impression of Grace, Ms B recalled that *"just from [Grace's] clothing and her hair, she stood out from the others who were in attendance. Her clothes just were ill-fitting. Like she could have quite small trousers on her but a ... large kind of baggy jumper or something... she stood out from the others."*

5.170 Regarding Grace's hair, Ms B told the Commission that it was *"just quite unkempt and just quite messy, like it hadn't been brushed at all that morning"* and as *"kind of tied up in a very haphazard way... nearly as though she had perhaps slept with it tied up and [had] just gotten up out of bed with it like"*.

5.171 Ms B also recorded Grace's hair as being "*quite greasy and matted*" when she attended Waterford Regional Hospital in August, 2008, a couple of months after Ms B had started work at the local voluntary association. On that occasion, Ms B further observed Grace to have poor hygiene, and noted that, when her "scrunchie" was removed when she was being x-rayed, the ends of her hair were tied together with blue elastic band.

5.172 Ms B told the Commission that there was a concern that Grace's clothes had not necessarily been purchased for her and that this, in turn, created a concern about potential financial abuse. Ms B said that "[t]here was no impact on [Grace on account of the fact] *that her clothes were not fashionable, other than for her own dignity that she did stand out against the other service users. I suppose it was an indicator of financial abuse that her money was not being spent.*"

5.173 Ms B described how much better Grace would look after swimming or after having a bath, saying:

"...she might have her teeth brushed after lunch or had been swimming and her hair would be neatly tied up and... she would just appear cleaner or better presented. Still in her clothes but better presented."

5.174 Ms B also observed that Grace's plastic keys were quite dirty and that they smelled because Grace never left them down and they never seemed to be cleaned.

5.175 Ms B said that, by August, 2008, a month and a half after she had commenced working with the local voluntary association, they were concerned about:

"... .how often [Grace] was being bathed or that her clothes were being washed and her general presentation was noticeably different than the other service users who were there in [Day Service Provider A]. I think my recollection at the time is that [Ms D] and the staff would have made some efforts to support [Grace] in that regard and not just [Grace] but other service users as well who would need assistance throughout the day that, you know tooth brushes were purchased...it wasn't commonplace for people to be showered or bathed in day service, that's not the function of the day service we provided. But

[Grace] would have had baths on occasion in day service and had her hair done, her nails done, that kind of thing, but there were days when on presentation to day service you would be concerned about the manner in which she was presented and whether her personal hygiene needs were being tended to appropriately”.

5.176 Mr. Smith’s note of the hospital visit on 20th August, 2008 (referred to above) recorded that Ms B told him that she was concerned about Grace’s appearance, her *“old and childish clothes, the state of her hair...how thin [Grace] was and the occasional marks on her.”*

5.177 Ms B told the Commission that she also noticed issues *“particularly around oral hygiene”* in the first few days of her meeting Grace. Grace’s dental care is reported in Section 9 below, dealing with her dental health.

Ms D

5.178 Ms D began work as the Manager of Day Service Provider A in March, 2008 and was still in that role at the time of her evidence to the Commission. She qualified as a learning disability nurse from a university in Scotland in 1998. After two years working in an admissions and treatment unit for people with challenging behaviours in Scotland, Ms D moved to a position in a nursing home for persons with intellectual disabilities.

5.179 In 2003, Ms D returned to Ireland from Scotland and moved to Waterford, where she worked in temporary positions covering leave with the Brothers of Charity. After four or five years, Ms D moved to the local voluntary association to work as a Clinical Nurse Manager, Grade 2. Her role entailed the operational management of Day Service Provider A. While this role was an office-based post, it also involved practical work in the service. There were around 33 to 34 service users in the day service, with five care staff, excluding Ms D. The care staff reported to Ms D, who in turn reported to Ms C.

5.180 Like Ms B, Ms D also had concerns about Grace’s appearance and personal hygiene during the period when Grace was living with Family X. She told the Commission that:

"[Grace] wasn't clean. She wasn't well presented and there would [have been] an odour from her as well. She wasn't groomed properly and [she] didn't present in age appropriate clothes. [Grace] didn't present very well at all. Her personal hygiene wasn't looked after appropriately."

- 5.181 Ms D said that Grace's hair was not groomed properly, that it had what she described as *"rats' tails"*, and that it was often tied up just in an elastic band. She also said that Grace's face was not clean. Ms D's view was that Grace's clothes were not appropriate *"for the young lady that she was"* and that her oral hygiene was *"really, really poor."* Ms D described Grace's clothes as *"very, very old"*, similar to items dating from the 1970s, and *"very, very worn"*. Ms D said that, if Grace had specific outings, some of the staff brought in their own clothes for her to wear.
- 5.182 Ms D told the Commission that the issue of Grace's clothes was not raised with Mrs. X in 2008, when Ms B started working at Day Service Provider A, but that it was certainly raised with her at the PCP meeting in July, 2009, when it was proposed that new clothes would be purchased for Grace on a day out that was being planned. Ms D's view was that, while Grace's clothes were an issue that related to her dignity, her attending day service five days a week was the priority and that, later, the question of non-accidental injury became the bigger concern.³⁵
- 5.183 Ms D said that Grace was incontinent at night-time and that, at the time of her involvement at Day Service Provider A, it appeared as though she was not being cleaned properly when she rose in the morning.
- 5.184 On 1st July, 2008, Ms B and Ms D met with Mrs. X. They discussed, among other things, Grace's presentation and her intermittent urinary incontinence. Mrs. X suggested that she would like Grace to attend the day centre five days a week, starting from the following Monday, and Ms D was happy to facilitate this. Mrs. X said that Grace was *"no trouble"* and that she enjoyed caring for her.
- 5.185 In the course of her evidence, Ms D described receiving a telephone call from Mrs. X on 10th July, 2008, after Grace had returned home from the day service, to enquire why she was incontinent of urine every Wednesday. Ms D recalled reassuring Mrs.

X that there was no change in Grace's programme. Ms D recalled thinking at the time that Mrs. X was not focusing on Grace's well-being, because she believed that focusing on Grace's well-being would have involved investigating her incontinence. She said that, rather than enquiring about Grace, Mrs. X was enquiring in relation to missing clothes or why Grace was incontinent of urine. In this regard, the evidence received by the Commission and reported below at Section 10 (Physical Health) reports on Mrs. X's taking Grace to see the general practitioner on 24th February, 1998 in connection with urinary incontinence and the general practitioner's checking if there was a link between that and a urinary tract infection, and again on 11th August, 2008. Reflecting at the Commission and qualifying her evidence on this matter somewhat, Ms D said:

"You see, I am questioning myself as well, maybe at that time I was concerned that [Grace] was incontinent of urine several times in one week, whereas now if [Grace] was incontinent of urine several times in a week I would not be as – I wouldn't be overly concerned about it because sometimes she is incontinent. So I don't know, you know, maybe at that point that we were being very very vigilant. At that point as well I don't think that I would [have] known [Grace] all that well either... Maybe as well if her days had [been] increased at that time, do you know, where we were seeing more incontinence because she was there more often".

5.186 Ms D told the Commission that Grace's incontinence problem continued at the time that Ms D gave evidence. The Commission is satisfied that this has been a long-standing issue throughout Grace's life.

5.187 With reference to a note dated 12th March, 2009 made by CW6 and counter-signed by Ms D, Ms D said during her evidence that there were discussions at Day Service Provider A about Grace's incontinence wear being the possible cause of the rashes which were observed around her buttocks or upper thighs. Ms D also surmised that the rashes could have arisen if hygiene was not being looked after properly or if incontinence wear was not changed appropriately or often enough. There was no evidence to the Commission of concerns having been raised previously in Day

³⁵ The concern with respect to whether there was non-accidental injury is considered and reported upon in Chapter 2 of this Volume.

Service Provider A about whether Grace's incontinence wear was changed appropriately or often enough before the time of this note of March, 2009. The Commission is satisfied on the evidence that Grace did have rashes from time to time, associated with the use of incontinence wear.

- 5.188 As reported in Section 3 above and in Chapter 2 of this Volume, it was evident at the Commission that managing Grace's incontinence was a matter of concern for Mrs. X as Grace's carer, particularly in the context of her attendance in Day Service Provider A and the bus travel to and from it.

Attendance to Grace's physical care needs

- 5.189 Day Service Provider A was founded in 1987 by a local voluntary association. The local voluntary association had been set up by a group of concerned parents of adult children with intellectual disabilities. It aimed to provide for the general care and welfare of "mentally handicapped" persons in the Waterford area by a committee under the chairmanship of a person who is now deceased.
- 5.190 The evidence received by the Commission with respect to how Day Service Provider A operated indicated in broad terms that matters became more formalised in the running of the centre as time went on. This included Mr. M's evidence of Day Service Provider A's becoming more regulated with time.
- 5.191 By the time Grace began attending Day Service Provider A in 1995, it had been based in its new facility for approximately five years and was catering for approximately 35 adult clients with various degrees of disability. In addition to the manager, Mr. M, a "Nurse Educator" was employed by Day Service Provider A. The "Nurse Educator" was Nurse N. By that stage, the building also contained a multi-sensory room which was seen as a big asset to Day Service Provider A.
- 5.192 It was apparent from the evidence to the Commission that, from the early days of Grace's attendance at the day centre, it had become part of the routine that attending to her physical care needs was part of the benefit of her attendance there. The evidence disclosed that staff took time to attend to Grace's hygiene needs as they saw them (in particular in the context of toileting), in that they bathed and showered Grace, washed her clothes when these were soiled, tended her hair, and sometimes attempted to brush her teeth.

5.193 It was clear from the evidence of Mr. M with respect to his communications with Mrs. X concerning Grace that he was focused on working with her to ensure that Grace got the benefit of her attendance. The consequence of this was that when Grace attended her day placement regularly, she benefited from this input with respect to her care needs.

5.194 This contrasted somewhat with Ms B's description of the approach taken by the day centre, as she understood it, when she started to work there in June, 2008. Ms B's evidence in this regard was that Ms D and staff *"made some efforts to support [Grace] in that regard and not just [Grace] but other service users as well who would need assistance throughout the day that, you know tooth brushes were purchased or people may have had – it wasn't commonplace for people to be showered or bathed in day service, that's not the function of the day service we provided. But [Grace] would have had baths on occasion in day service and had her hair done, her nails done, that kind of thing, but there were days when on presentation to day service you would be concerned about the manner in which she was presented and whether her personal hygiene needs were being tended to appropriately."*

5.195 On the evidence to the Commission, the day centre had not taken issue with Mrs. X about its attending to Grace's physical care needs when she came to the centre. On the contrary, the evidence suggested that Mr. M and the staff simply did their best to attend to Grace's care needs. Mr. M took Grace as she presented, and the Commission is satisfied that, as manager of the centre, he saw a role for it in attending to Grace's care needs as they presented and as required. As noted above, Mr. M was focused on working with Mrs. X so that Grace would continue to attend, and would have the benefit of attendance at, the centre.

Statement of bus driver (Mr. H)

5.196 Mr. H was the main bus driver who operated the bus throughout Grace's time in Day Service Provider A. He passed away before the Commission was established.

5.197 In the course of its investigations into Grace's case, An Garda Síochána took a statement from Mr. H on 4th October, 2012 with respect to his memory of her on the bus. This is also referred to in Chapter 2 of this Volume.

5.198 With regard to Grace's presentation, Mr. H said in his statement that Mrs. X "*would bring her out [to] the bus very morning and collect her. [Grace] would be dressed immaculate[ly] and hair done well...*" This was not a matter that could be further explored with Mr. H in evidence.

Evidence of Family X and other household members- February, 1989 to July, 2009

Mrs. X

5.199 The most direct evidence about what was involved in the care of Grace on a day-to-day basis came from Mrs. X. Mrs. X was Grace's foster mother and primary carer from the age of 10 until Grace was removed from her care at 30 years of age. Mrs. X was the person who assumed primary responsibility for carrying out the tasks involved in providing for Grace's day-to-day care needs and who spent the most time with her over the 20 years of Grace's care investigated by the Commission.

5.200 Much of the evidence with regard to the above is reported in Chapter 6 of this Volume, which includes Mrs. X's evidence on day-to-day life, and which should be read in conjunction with this Chapter.

5.201 Mrs. X's evidence was that nobody, including Mr. M or Ms D, had ever said to her that Grace was arriving into Day Service Provider A in a poor state or that she did not look great or that she was not washed or anything of that nature. The evidence to the Commission supported this. The Commission had evidence of communications between Mrs. X and Mr. X and Day Service Provider A which related to changes of clothing or the return of clothing when Grace had to be changed, rather than the condition, suitability, or style of Grace's clothes, or Grace's standard of hygiene.

5.202 Further, there was no evidence to the Commission that the condition, suitability, or style of Grace's clothing was a matter raised with Mrs. X by any official of the SEHB or the HSE over the time that Grace was in Mrs. X's care, until it was raised at the PCP meeting for Grace in July, 2009.

Mrs. X's evidence regarding Grace's clothing

5.203 Mrs. X told the Commission that she bought Grace's clothes in shops in a nearby provincial town, but she was unable to say to which shops she went. Mrs. X said that

when she bought Grace new clothes or shoes, Grace would rip them off and not wear them. However, she also maintained that she did not stop buying new clothes for Grace. The Commission found Mrs. X's evidence to be contradictory and unreliable on this issue. Given the descriptions about Grace's clothes given in the evidence, in particular from care staff in Day Service Provider A, the Commission is not satisfied that Mrs. X did purchase new clothes for Grace on any regular basis. The descriptions of Grace's clothes tended to suggest that they were old and (although not directly stated in the evidence) appeared to be second-hand or handed down.

- 5.204 Mrs. X maintained in her evidence that there was nothing unsuitable or substandard about the style of clothes that Grace wore. On the contrary, Mrs. X considered that she dressed Grace well and in clothes such as pants, jumpers and runners as she thought appropriate, describing Grace as the "*best-dressed girl on the bus*". She said that Grace did not like to wear skirts.

Mrs. X's evidence with regard to showering/bathing Grace

- 5.205 Mrs. X told the Commission that Grace was showered or bathed at night before going to bed. She wore incontinence wear at night and was changed in the morning. If she was going to her day placement, Mrs. X said that Grace had a shower at about 7.30 a.m. However, at the PCP meeting with Mrs. X on 3rd July, 2009, according to Ms B's notes, Mrs. X was asked for the first time if there was any possibility of her being able to bath or shower Grace in the mornings rather than the night before and that Mrs. X had said that she would try to do that (Grace was removed from Mrs. X's care two weeks later). The Commission cannot establish from the evidence as to when or how often Grace was showered or bathed at home. Having regard to the evidence, however, the Commission cannot be satisfied that this occurred on a daily basis. At this stage, Mrs. X was 73 years old and had been caring for Grace for 19 years.
- 5.206 Mrs. X told the Commission that, if Grace was going to Day Service Provider A, she would wake at 7.00 a.m. and have her breakfast. Mrs. X said that she then put Grace in the shower at approximately 7.30 a.m. and dressed her. Mrs. X said that Grace needed assistance showering. She also said that Grace preferred baths, but that showers were quicker and easier for Mrs. X to manage.

5.207 As regards the washing of Grace's hair, Mrs. X said that she did this every second day. Grace's hair was long and Mrs. X said that she used to put it in a plait. She dried Grace's hair with a hairdryer.

5.208 Mrs. X said that she tended to dress Grace in jeans or tracksuit pants, jumpers, shirts and ankle boots or trainers. Mrs. X said that Grace would then be ready for collection by the bus driver at 7.45 a.m.

5.209 In a handwritten note from Mrs. X to Nurse N in Day Service Provider A, undated but written sometime between 1995 and 2000,³⁶ Mrs. X wrote:

"I need your help regarding [Grace]'s hair. Every morning I send her out with her hair plaited and [hair] bands to keep it in place. When she arrives back home she looks more like a scarecrow, hair all over the place no bands or clips. Now I am assured this does not happen on the ambulance. Now [Grace] is not able to touch her hair, she can't even take the bands off so can you throw any light on what's happening. I am considering having her hair cut short on Wednesday what do you think. I am not moaning but it is disheartening when this happens. hope you can help. Thanks a lot."

Grace's personal hygiene

5.210 With respect to the evidence taken by the Commission concerning Grace's hygiene and the reference to odours from her clothing, this was, at times, attributed by witnesses to incontinence, at times to the condition of Grace's teeth/gums and, at other times, to what was described as a musty smell emanating from Grace's clothing. Not all witnesses noticed this feature of Grace's presentation and it is also clear from the evidence that this problem was not always present. It was certainly the case, on the evidence, that the management of Grace's incontinence was a constant issue for Mrs. X. While she did not acknowledge any deficits in the way that she managed Grace's personal hygiene around this difficult issue, the evidence nonetheless pointed to some deficits in attending to Grace's cleanliness in this regard. Grace's dental care is reported separately below. It would appear from the evidence on the issue of odours that Mrs. X had, in all likelihood, become used to this

³⁶ Nurse N worked at Day Service Provider A from 1994 to 2000.

aspect and either did not, or could not, raise her standard of care to address these issues fully.

Mrs. X's work outside the home

5.211 The evidence established that Mrs. X worked part time in a local business for a neighbour for periods between 1990 and 1991, when Grace was placed with Family X. There was limited evidence of Mrs. X's also doing some part-time work in another house in 1996.

5.212 Mrs. X also told the Commission that her daughter (since deceased) "*minded [Grace] for a couple of years... I was there with her all the time... But if I had to go the shops or something she would mind [Grace].*"

5.213 The Commission cannot rule out that there may have been occasions when Grace was minded by Mr. X and there was evidence also of Grace's sometimes being driven in the car by Mr. X or Gamma, going to the shops.

5.214 However, the Commission is satisfied on the totality of the evidence that Mrs. X was the person in charge of and who tended to Grace's care needs at home, notwithstanding any periods of part-time work outside the home.

Evidence of other household members – February, 1989 to July, 2009

Preliminary

5.215 The evidence of Mrs. X's grandson, her nephew, and a lodger who lived in an outbuilding on the property was of assistance to the Commission in providing some ordinary detail about Grace's life at home and elements of her care. Aspects of their evidence are also reported in other chapters of this Volume (which should be read together).

5.216 The Commission did not receive any evidence, nor was any assertion made at the Commission, that the household members, whose evidence is considered below, were involved in the day-to-day care of Grace. The Commission had no evidence to suggest that the household members were involved in any way in any alleged neglect of Grace, including the neglect of her care needs.

Alpha

5.217 The evidence of Mrs. X's grandson, Alpha, with respect to Grace was a direct account from his childhood memories growing up within Family X. Alpha grew up with Grace and spent every day with her (apart from when she was at Day Service Provider A) before he started attending primary school himself. He was 10 years younger than Grace and gave evidence of how he considered her to be his sister during his childhood. He spent a considerable amount of time in her company as a young boy. The local schoolmaster told the Commission that he recalled that Grace would often be in the car when Alpha was brought to or picked up from school. As Alpha got older, he was off at school and essentially doing his own thing.

5.218 With respect to Grace's presentation, Alpha's evidence to the Commission was that Grace was always dressed well, commenting that *"I would never have took any notice of that...she was dressed and very well dressed"*.

5.219 Alpha described Grace as always having a *"fantastic appetite"*. This evidence corresponded with evidence given to the Commission by other witnesses, to the effect that Grace had a very good appetite.

5.220 Alpha was adamant in his evidence that Grace was not subjected to neglect in the household, saying: *"Never. It is not possible."* He elaborated on this as follows:

"Because [Grace] was nicely dressed, fed better than myself... it was just something that the love and affection that that girl got off of my grandmother was second to none, and that is my own heartfelt opinion on that".

5.221 It was evident that Alpha was upset at the nature of implicit criticism in the matters for investigation by the Commission regarding Mrs. X's day-to-day care of Grace and the insinuation that she had neglected Grace physically. On his evidence, a picture of Grace as neglected ran contrary to his own experience of her as he grew up in the household, to how he remembered her, and to his own view of the standard of her care.

Gamma

- 5.222 Gamma, Mrs. X's nephew, lived in an outbuilding at the back of the home of Family X until 2000, when Mr. X died. Gamma then moved into the main house, where he continues to reside.
- 5.223 With respect to Grace's clothes, Gamma told the Commission that Grace was presented "*well enough for anyone, very good*". He said that he never saw any difficulty at all about that.
- 5.224 Gamma also remembered Grace as having a good appetite and remarked that there was never any shortage of food in the house. Gamma told the Commission that he never saw Grace being denied anything like food or being neglected in any way. In this regard, he said that: "[Mrs. X] *wouldn't deny anyone, the cat even, if I can put it that way to you*".
- 5.225 Gamma was also upset by the allegations about Grace's physical care, of the kind that he was asked to comment upon at the Commission. These did not accord with his own view of Grace's treatment in the house or how she was cared for. The Commission heard evidence that, when he was not at work, Gamma helped out with practical work around the property and drove Mrs. X and Grace around after Mr. X became ill and could no longer do so.
- 5.226 Gamma did not see Grace as a person who was neglected or abused within Family X. His view, on the contrary, was that Grace was never mistreated at home. He told the Commission that he had never seen her mistreated or neglected.

Beta

- 5.227 Beta had lived at the back of the property before Grace came into foster care in 1989 and he worked locally. In the course of his involvement in Grace's case, Mr. Smith raised a question as to whether Beta should be regarded as a vulnerable adult but he concluded that this was not the case. This aspect is reported in the context of the management of Grace's case within the HSE in the Garda Volume.
- 5.228 Beta gave the Commission evidence of his best recollections of Grace in the household. In terms of her clothing, Beta said that, when Mrs. X looked after Grace,

she made sure that she looked after her well. Beta said that he did not see Grace having meals because she had her meal with Mrs. X and he ate separately in the kitchen. He described the food that Mrs. X would give him as better than “*the best of grub*”. Beta said that Grace had a good appetite, a big appetite.

- 5.229 Beta told the Commission that he never saw anyone neglect Grace. He said that he never saw anybody leave her without anything that she needed and that Mrs. X looked after her “*a thousand to one*”.

Evidence of other persons who encountered Grace in the placement with Family X at particular times

Preliminary

- 5.230 The Commission also received very limited evidence from a small number of persons, unconnected to Family X, the local voluntary association, and the SEHB/HSE, who were able to provide an account of Grace’s presentation from their observation of her in her placement.

- 5.231 In reporting in this Chapter on the question of Grace’s presentation, her care, and on the question of whether she was neglected, the Commission has considered the evidence that specifically assists one way or the other on these matters. Issues concerning other service users and their particular experience in the placement are not the subject matter of this Chapter or Volume of the Commission’s report. The extent to which these may be investigated later is a matter to be determined at the conclusion of Phase One of the Commission’s investigations in Grace’s case.

The Q family

- 5.232 Q.Q., a girl with an intellectual disability, stayed with Family X by way of a private arrangement when she was aged between 12 and 33 from around 1992 until 2013. She stayed on a “*needs must arrangement*” from 1992 and generally stayed with Family X during the week over the period in question.

- 5.233 The evidence of Q.Q.’s parents and an assistant for Q.Q. about Grace’s presentation when they met her in the house over the time that Q.Q. stayed there was generally positive.

- 5.234 Q.Q.'s mother told the Commission that she met Grace all the time while she lived with Family X. She gave evidence that Grace was always very clean and well dressed, with her hair *"perfectly in a plait"*. She recalled that Grace's skin was poor and that she had acne. Q.Q.'s mother said Grace was always very clean and well dressed for as long as she could recall and that, although she might not have seen Grace for quite some time prior to her removal from Family X, she never saw any difference in her.
- 5.235 Q.Q.'s father worked away a lot. He told the Commission that he could not recall going to Family X's in the very early stages of Q.Q.'s staying there, but said that he was certainly there on occasions. He explained that he used to have to leave for maybe six to eight weeks with work, and that if Q.Q. was with Mrs. X he would visit to spend some time with her. Q.Q.'s father recalled that Grace was frequently in the house when he visited his daughter. His recollection of Grace was that: *"[s]he was in a little world of her own. She played with her keys or maybe some other toy and all I recall that if [Q.Q.] happened to grab the keys she would quickly grab them back, stuff just simple child stuff like that...But she seemed very well cared for, well dressed, and well looked after. She didn't seem in need of anything.... She appeared to be quite happy"*.
- 5.236 In their evidence to the Commission, neither of Q.Q.'s parents gave evidence of Grace's presenting poorly or of any level of neglect.
- 5.237 The Commission also heard evidence from Q.Q.'s aunt. She said that she briefly saw Grace when she accompanied Q.Q.'s mother to Family X's in 1992 before Q.Q. started staying there. Q.Q.'s aunt recalled that Family X's house seemed like a *"nice house, comfortable and warm."* She said that Grace seemed *"well dressed and happy looking"*. Her visit to the house was not long enough for her to see Grace's interactions with Mrs. X. Subsequently Q.Q.'s aunt was only at Family X's on several occasions, dropping off or collecting Q.Q. She had no further interaction with Grace.

Ms P

- 5.238 Ms P worked as a care assistant to Q.Q. From 1999 to 2013, she collected Q.Q. from the home of Family X but did not go into the house. On one occasion, in 2005, Ms P recalled being invited into the house and meeting Grace briefly. Ms P said that her first thought was that Grace was *"beautiful"*, with blonde, fair hair. She also

recalled that Grace had acne. Grace was wearing a red jumper and was sitting at the table shaking plastic keys that she held in her hand. Ms P said that, on this particular occasion, Grace's clothes were "*really clean*" and her hair was "*freshly washed*".

Neighbour A

5.239 Neighbour A was a neighbour of Family X who operated the local business that Mrs. X worked for on a part-time basis for a time (reported upon at paragraph 5.211 above). Neighbour A said that she had nothing negative to say about Grace's relationship with Mrs. X or Grace's appearance or treatment.

5.240 Mrs. X minded Neighbour A's children regularly in Family X's house from 1984/1985 to 1988/1989 when they were young. Mrs. X also minded the children occasionally when they were older. Neighbour A got to know Mrs. X quite well over this period.

5.241 Neighbour A told the Commission that she remembered going to Mrs. X's house at some point and being introduced to Grace. She recalled Grace as fair haired or blonde and described her as being "*quite disabled*". She could not recall how many times she saw Grace over the years. With respect to Grace's relationship with Mrs. X, Neighbour A told the Commission:

"I would have had no concern is probably the easiest way to say it. As far as I was seeing it, it was fact...I didn't see and I don't have in my mind any reason why I would have thought of it negatively or have remarked on it in any way".

Neighbour A's daughter

5.242 Neighbour A's daughter, who was minded by Mrs. X, remembered going to Mrs. X's house for that purpose. She was around three or four years old when she went there first. She and her sibling were minded by Mrs. X intermittently and stayed overnight on occasion. Neighbour A's daughter remembered Grace as one of two of girls who had disabilities staying at Mrs. X's house. Being a young child, it was the first time she had an association with someone who was severely disabled. She remembered, from time to time, Mrs. X's giving Grace dinner or tea or having Grace outside if it was a sunny day. She described Grace as being in her "*own world*". Speaking of how

Grace was treated in the home of Family X, Neighbour A's daughter said that, while Mrs. X was usually "*quite straight or stern*" with the children, she was slightly more patient with Grace.

Neighbour C

5.243 Neighbour C knew Mrs. X from the locality. She moved to England and, when she returned on visits, she brought clothes and other items that Mrs. X's daughter sent to Mrs. X.

5.244 Neighbour C described Grace as being a "*nice child*" and recalled her sitting in a chair and being "*mobile*". Neighbour C gave evidence of how it would upset her to see Grace hitting her teeth with a rattle, saying "*you couldn't stop her no matter how you tried*". She recalled that Grace would tap the rattle (seemingly a reference to Grace's plastic keys) off her teeth all the time until she drew blood. On Neighbour C's evidence, this was the only problem that she saw with Grace.

5.245 Neighbour C also recalled an occasion when Grace went to the bathroom and was in it for a very long time on her own. She thought that she probably asked Mrs. X why Grace was taking so long and that Mrs. X told her that Grace just took her time.

5.246 Neighbour C said that Grace liked to dress up and that she brought her some nice dresses that her own daughters had grown out of. Neighbour C said that Mrs. X "*absolutely loved*" Grace.

The local schoolmaster

5.247 The observations made by the local schoolmaster of Alpha's primary school about Grace, Alpha, and Mr. and Mrs. X have been reported in Chapter 8 of the Commission's First Substantive Interim Report. Insofar as he had opportunities to observe Grace, in the manner reported in that chapter, his impressions of her overall care were conveyed as positive and good. He described what he saw of the relationship between Mrs. X and Grace at that time as being like "*a grandmother or a very loving person that was responding to a person with needs.*"

5.248 The local schoolmaster told the Commission that he thought that Grace looked "*fine*" insofar as her presentation was concerned. He said that there was no sign for the

local people that there was anything untoward happening or might be happening there. He said that Alpha was coming from the same house and that he was always turned out *“perfectly well”* for school. The local schoolmaster said that *“between lunches and whatever”*, there was never any sign of any neglect towards Grace or Alpha.

Local voluntary service board member

5.249 A member of the board of the local voluntary association whose son had stayed with Family X for three consecutive summers from 1987 to 1989 gave evidence to the Commission of her recollections of Grace in Family X's.

5.250 The board member said that she remembered vividly her first interaction with Grace in Family X's house. When she first saw her, which was about four months after Grace had arrived, she recalled her presentation as *“dreadful.”* Grace had curly blonde hair and the board member said that she did not know how one would attempt to comb it or brush it. She also recalled that Grace was drooling. The board member said that Mrs. X. told her that Grace was doubly incontinent. She remembered Grace as being covered in a rash and scabs, and told the Commission that she looked *“awful.”*

5.251 The board member said that Grace responded very well to Mrs. X. She said that when she went to the house the following weekend, she saw a little change in Grace for the better and that, eventually, Grace had no special diet, no incontinence and no rash on her skin. She told the Commission that while Grace did not talk at all, she could communicate and looked happy.

5.252 The board member distinctly remembered seeing Grace sitting in the back of Family X's car, which she thought was the following summer. She said that there were three children in the back of it and that Grace was laughing and fighting with the child by the window because she wanted a turn at it. It was *“all fun.”* The board member said that Grace had *“a yellow skirt and blue stockings and a pink bow and God knows what else on her, but she was a happy child.”* She said that she also saw huge changes in Grace's expression and her face, as well as in her physical condition and in her devotion to Mrs. X.

5.253 The board member's evidence was that Grace was *"very fond"* of Mrs. X and got on fine with Mr. X.

5.254 After her son had finished staying with Mrs. X on respite, the board member went occasionally to visit Mrs. X. She recalled that the house remained the very same. Asked about Grace's presentation on those visits, she recalled that Grace *"would kind of hug herself near [Mrs. X] but she wasn't afraid, or anything, she was just secure when she was with [Mrs. X]"*. She said that *"[s]he looked fine. She was getting bigger and she was getting not so kind of cuddly, more lanky kind of"*.

5.255 The board member said that Grace had no speech but that she behaved in a very normal way. She recalled Grace's clothes as being *"[e]very colour in the rainbow, but nothing dirty"*. The board member said that she stopped going to see Mrs. X once Grace went to Day Service Provider A (which occurred in 1995).

Dr. Mary O'Gorman

5.256 Dr. Mary O'Gorman, General Practitioner and Forensic Examiner at the Sexual Assault Treatment Unit in Waterford Regional Hospital, only saw Grace on one occasion, when she was brought to hospital on 27th March, 2009. The events of that day are reported in Chapter 14 of Volume 1 and are also referred to in Chapter 4 of this Volume. Dr. O'Gorman's impression was that, insofar as the question of Grace's appearance was concerned, there was no issue with her, other than the bruises that she observed in the course of her examination.

5.257 Commenting on Grace's appearance, Dr. O'Gorman told the Commission that:

*"[o]ther than the injuries, she looked well kept and well cared for."
"She hadn't a dishevelled appearance of her hair. Her clothing was appropriate to what you would expect of a woman of that age...and they weren't torn in any way...[her hygiene] was good." "...with an intellectual disability you would have to allow...for behavioural...attitudes and things and...being in a strange unit, she's going to be a bit nervous and upset...she was thin but she wasn't emaciated."*

5.258 In considering this evidence, the Commission has regard to the fact that Grace was showered and changed in Day Service Provider A that morning, before being taken to hospital.

5.259 Dr. O’Gorman did not have any concerns as regards Grace’s body weight or her general care.

Other medical personnel

5.260 The evidence of Dr. F, general practitioner, who saw Grace at intervals over the years that Grace was in the care of Family X, is dealt with in detail at Section 10 below. That Section also includes the evidence of Dr. G, general practitioner, who examined Grace in October, 2008.

5.261 The evidence of Dr. Walsh, SEHB Acting Senior Area Medical Officer, who reviewed Grace in 1992 and 1995, is also considered in that Section.

5.262 It should be noted at this juncture that none of the above health care professionals raised any concern with respect to Grace’s overall appearance, presentation, or personal hygiene.

Evidence of personnel regarding Grace’s presentation on arrival at her new residential placement on 17th July, 2009

Ms R

5.263 Ms R was a nurse in the residential unit when Grace moved there on 17th July, 2009. She told the Commission that her impression of Grace when she first arrived at her residential placement was that she was very dishevelled and that her teeth were in a very bad state, describing her breath as “*stinking*” and her hair as unclean. She also described Grace as not clean. She said that Grace’s clothes were very old and everything “*looked second-hand and not great*”. That feature was not necessarily a cause for concern because, she observed, she did not know where Grace had come from. In this regard, Ms R surmised that some parents did not care too much about clothing. She described Grace’s clothing as not filthy but “*just very old, and they weren’t folded*” and that “*there wasn’t much care in them*”. Ms R told the Commission that she was, however, concerned about Grace’s overall physical appearance. Further evidence given by Ms R is reported in Chapter 4 of this Volume.

Ms S

5.264 Ms S qualified as a psychiatric nurse in St. Brendan's in Dublin in 1992. She returned to Waterford and worked in intellectual disability with the Brothers of Charity from 1992 to 2007. In 2007, she applied for and secured a position in the local voluntary association as a Clinical Nurse Manager and worked there in that capacity from 2007 until 2014. Between 2004 and 2008, Ms S obtained her BSc Honours Degree in Nursing.

5.265 Ms S first met Grace in July, 2009. She told the Commission:

"[i]n terms of her presentation...[Grace] appeared to me like a little lost child, she was neglected looking, her hair, she was unkempt...Her clothes were unkempt. She was untidy. Her hair was untidy. Her teeth needed attendance too. It would seem like it was a long time since she had dental treatment. Clothes very untidy. Hair unkempt. And in general just unkempt looking."

5.266 Further evidence given by Ms S is reported in Chapter 4 of this Volume.

Grace's clothes delivered to Day Service Provider A – August, 2009

5.267 On 19th August, 2009, two brown cardboard boxes were left in the porch area of Day Service Provider A with Grace's name on each box. The boxes, which contained clothes, were delivered to Day Service Provider A on Mrs. X's behalf.

5.268 Ms B made a note at the time that there was a "*strong odour coming from the clothes*" and that three garments were "*noticeably stained*". She noted that there were no belongings, documents, or photographs in the boxes, other than the clothes.

5.269 Ms B told the Commission that some of the items of clothing were "*quite stained or dirty*". She thought that it was unlikely that Grace was going to wear many of the clothes, explaining that Grace had had a lot of clothing purchased for her in the intervening time, which Ms B said was in much better condition and was much more suited to Grace.

- 5.270 Ms B told the Commission that she and the other staff at the local voluntary association were familiar with some of Grace's clothes contained in the boxes, but that there were others which she had not seen before. She said that they were in "*a variety of sizes and in a variety of conditions.*"
- 5.271 In particular, Ms B recalled that some of the items of underwear included in the boxes were "*clearly newly purchased but opened*" and, although removed from their packaging, still had the cardboard inserts of the packaging in them. Ms B recalled that some of these new items of underwear were also the wrong size for Grace, some being a size 14, whereas she said that Grace would have been a size 6 to 8 at the time.
- 5.272 The new items with the cardboard inserts obviously were not items that Grace had ever worn. Given the evidence about Grace's incontinence wear, her care in Day Service Provider A, and the changes of underwear sent into Day Service Provider A with her over the years, it was evident that the new items, which included thongs, were not in the style that Grace wore. In particular, there was no evidence to the Commission that Grace wore thongs as underwear. It is also evident that some new items of underwear were purchased for delivery in the boxes, and the Commission is satisfied that, in all likelihood, the new underwear was randomly selected for purchase without proper attention or reference to style or size.
- 5.273 Ms B said that she was keen to keep the clothing that had been delivered in the boxes, so that it could form what she understood would be an "*assessment or a review of the concerns of neglect with respect to [Grace]*". She said that she logged each item of clothing and photographed them so that there would be a record maintained of what exactly was returned to Grace after the 20 years that she had spent with Mrs. X. The Commission was provided with these photographs, which showed a variety of clothing by way of t-shirts, tops, jumpers, pants, tracksuit pants, underwear, shoes, socks, and hair ties. Some stains or signs of shabbiness were visible on some of the items that were photographed and showed evidence of neglect. The Commission is satisfied that, apart from the underwear referred to at paragraphs 5.271 and 5.272 above, the garments included were of the type and style generally described as worn by Grace over the years.
- 5.274 In her note about the delivery of the two boxes to Day Service Provider A, Ms B recorded that she telephoned Mrs. X as she wanted to ask if it was she who had left

them in and why she did not wish to give them to the staff of the local voluntary association directly or to see Grace. She also recorded that she had wanted to ask Mrs. X why she did not want her (Ms B) to collect the items from her home. Ms B's note recorded that there was no answer to her telephone call and that she did not get to speak to Mrs. X about the delivery of the two boxes of clothing after that.

5.275 In her cautioned Garda statement dated 21st September, 2012, Mrs. X said the following: *"I used to buy clothes for [Grace] in [a nearby provincial town], new clothes, sure I dropped two boxes of them in to the day care service for [her] when she left."*

5.276 Later in the same interview, when queried about the old clothes that were left in the porch at Day Service Provider A, Mrs. X said: *"they weren't old clothes, it was what she was using at the time. I bought one [or] two things, a brown mac, shoes and put them into it. My nephew brought it for me, he went to [Day Service Provider A] and left them there. The doors were open and no one [was] attending so he left them. I said 'Why didn't you leave them at [House 2, the residential unit to which Grace had moved]?' He told me he couldn't find it and went to [Day Service Provider A]".³⁷*

5.277 The Commission wrote to Mrs. X about this matter on 12th November, 2021. Mrs. X responded by way of letter received by the Commission on 17th November, 2021. The letter stated that Mrs. X was not well and that she *"doesn't remember anything about [Grace's] clothes."*

Findings with respect to Grace's presentation

5.278 Without detracting from the detail of the evidence considered above, certain matters that arose may be summarised as follows:

1. the Commission is satisfied, on the totality of the evidence, that Mrs. X was Grace's primary carer over the period that she was placed in foster care and thereafter when the SEHB decided that she should stay with Family X, as reported in both the First and Second Substantive Interim Reports;

³⁷ The local voluntary association had a high-support respite house in the Waterford area, referred to in the Commission's reports as House 2, while House 3, also in the Waterford area, was a low-support respite house which was open every second week for overnight residential respite.

2. there was no evidence to the Commission that was critical of Grace's overall presentation or her personal hygiene, or that raised a concern in the SEHB that she was being neglected by Mrs. X, with respect to the period of her childhood in foster care with Family X. The Commission has reported in detail in the First Substantive Interim Report upon all aspects of the management and monitoring of Grace's case, including upon certain deficits/failures in the monitoring of her over that period. These notwithstanding, the monitoring of Grace's case that did take place did not raise a concern that she was neglected. There was also no evidence from other sources to establish that Grace had been subjected to neglect with respect to her presentation, appearance, or personal hygiene over that period;
3. with respect to the evidence of SEHB/HSE officials who encountered Grace as a vulnerable adult (reported above), the only observation of significance concerning her presentation was that of Ms Jones, Social Worker, who noted in evidence that, insofar as Grace's teeth were concerned, she was "*close to the line of needing extra care in terms of hygiene*" in January/March, 1999 (dental issues are reported separately below in Section 9);
4. Ms Leyshon, Social Worker, who took over from Ms Jones in March, 1999 and left in May, 2001, did not have a concern about the standard of Grace's presentation or mode of dress. Her work in Grace's case has been reported in the Second Substantive Interim Report and above;
5. there was no evidence of any kind from SEHB/HSE personnel about Grace's presentation between May, 2001 and September, 2007 in circumstances where, as reported in the Second Substantive Interim Report, there was no monitoring of Grace's care in her placement over that time period;
6. the concerns of Mr. Smith and Ms Griffin with respect to Grace's presentation later on in September, 2007, when the HSE re-engaged with Grace's case, have been reported above;
7. the evidence reported above from persons available to the Commission who had seen Grace or had passing encounters with her in her placement over the years (other than professionals involved in her care) was generally positive with respect to her appearance and presentation, and did not raise

any issues of concern in that regard. That evidence tended to relate more to the earlier rather than the later years during which Grace resided with Family X;

8. the evidence reported upon above from members of the Family X household with respect to Grace's presentation was also positive and did not raise any issues of concern in this regard;
9. notwithstanding the lack of monitoring by the SEHB/HSE from May, 2001 to September, 2007, the Commission had available to it evidence with regard to Grace's presentation from staff of Day Service Provider A, which Grace attended over the period from September, 1995, when she was 16 years old, till she was removed from the placement in July, 2009. The significant differences reported in this Chapter between the views given in evidence by some staff members and those of Mr. M, the Manager of Day Service Provider A until 2008, are referred to further below;
10. the Commission also had evidence of concerns expressed with respect to Grace's appearance and presentation from Ms B and Ms D, who joined the staff of Day Service Provider A/the local voluntary association in 2008;
11. the Commission also had the evidence of Ms Burke, Independent Advocate, who first encountered Grace in the first half of 2009, reported above, with regard to her concerns about Grace's presentation at that stage;
12. there was no evidence of any concerns with respect to Grace's presentation, her manner of dress, or her personal hygiene having been raised directly with Mrs. X or Family X by officials of the SEHB/HSE over the years that Grace was in Mrs. X's care. The matter of Grace's dental care is reported separately below;
13. further, insofar as the issue of Grace's presentation was concerned, communications between Day Service Provider A and Mrs. X and Mr. X generally related to such matters as the return of clothes on those occasions when Grace had been changed due to an incontinence incident. The suitability of Grace's clothing and the condition of her hair were not raised as concerns with Mrs. X over the years (the PCP meeting that occurred in July,

2009, where it was proposed that Mrs. X provide a sum from Grace's Disability Allowance for new clothing and a visit to the hairdressers, is reported above);

14. the issues raised with respect to Grace's presentation, outlined in the evidence, were in the area of welfare concerns, and related to the standard of care that was being provided to Grace in her placement;
15. with regard to the detail in the evidence reported above, there were at times significant differences in the impressions conveyed by witnesses about Grace's appearance and presentation over the years that she lived with Family X. Consequently, the evidence tended to vary with regard to whether or not Grace's presentation was such as to give rise to concern that she was not receiving adequate care. The factors that tended to explain these differences across the evidence, in broad terms, are referred to at paragraph 1.12 *et seq.*, entitled "The evidence", above. Some differences were inevitable taking into account the fact that evidence was heard relating to varying time periods and the circumstances pertaining at those times. These differences also arose from witnesses' differing perspectives and opinions about Grace's presentation at particular points in time; and
16. the Commission does not consider this to be unusual. A consistent or entirely uniform picture of Grace's presentation and of the standard of her care over the entire 20 year period under investigation was unlikely to emerge from evidence coming from many different viewpoints, extending as they did over the lengthy time period in question.

5.279 Considering the entirety of the evidence heard with respect to Grace's presentation over the years, including the evidence from staff of the day centre, the Commission has found the following.

Clothing

5.280 As Grace's carer, Mrs. X was the person who provided Grace's clothing. These were funded from the foster care allowance/children's allowance when Grace was in foster care, and thereafter from Grace's Disability Allowance. If Grace's clothing had once been purchased as new, by the time she began to attend the day centre in 1995 her

clothes appeared well used and were seen as dated by some members of staff. It is a reasonable inference from the evidence that, in all likelihood, Grace wore some clothes that she had had in earlier years well into adulthood, or that clothing purchased was of a second-hand variety. The evidence to the Commission indicated that Grace's style of clothing did not change over time and that there was no appreciable difference between the style of her dress as a child and as an adult.

- 5.281 The evidence established that Grace's clothes were functional for her day-to-day activities. The type of clothing worn was influenced by what was practical and comfortable in terms of dressing and undressing, a task with which Grace always required assistance. Grace often wore tracksuit bottoms. Her clothes sometimes needed to be changed during the day, due to her incontinence, and also for swimming activities and for showers or baths in Day Service Provider A.
- 5.282 Mrs. X's account of often buying new clothes for Grace was not supported by the evidence of their appearance as observed at her day placement. Mrs. X's evidence was vague and contradictory on this matter and the Commission cannot accept it as correct.
- 5.283 Mrs. X maintained in her evidence that there was nothing unsuitable or substandard about the style of clothes that Grace wore. On the contrary, Mrs. X considered that she dressed Grace well in clothes such as pants, jumpers and runners, describing her as the "*best dressed girl on the bus*". The Commission is not satisfied, however, that her view of Grace's standard of clothing was borne out by the totality of the evidence on this issue. Mrs. X's evidence on the issue was accompanied by the assertion that she always bought new clothes for Grace. The fact that this was incorrect, in itself, undermined Mrs. X's assertion as to the standard of Grace's clothes.
- 5.284 The question as to whether the type or standard of the clothes in which Grace was dressed over the years was such as to raise a concern that she was neglected, is a particularly subjective one. This was amply demonstrated through the evidence of Mr. M and that of other witnesses reported in this chapter. As already reported, by 2001 (before Grace's case slipped from view), no issue regarding the manner in which Grace was dressed had ever been raised with Mrs. X by SEHB/HSE personnel involved in her case.

- 5.285 With respect to the differences in the evidence that emanated from Day Service Provider A personnel concerning Grace's presentation, broadly relating to the period up to 2007, the Commission accepts that Mr. M's evidence about Grace at Day Service Provider A was a true reflection of his views and perspective over that time about how she appeared and her presentation in the day centre. The Commission also accepts that the evidence given by a number of the care staff who worked with Grace reflected their views on how she presented at the day centre over that time.
- 5.286 However, with respect to the difference in the evidence of Mr. M and some of the care staff as to the condition or suitability of Grace's clothing, the Commission notes that the care staff were engaged more closely with Grace's personal care needs and accordingly were more focused on the quality and condition of her clothing and her presentation. The Commission accepts their recollections of the standard and condition of Grace's clothing and is satisfied that the descriptions of her clothes as old-fashioned, with an old or worn appearance at times and being of a basic variety, were substantially accurate. Further, the difference in Grace's presentation by virtue of her style of clothing, which was of inferior quality to that of some of the other service users, was noticed by several members of staff in the day centre. The description of some witnesses of Grace's clothes as ill-fitting, however, was not a feature that was reported consistently in the evidence provided and it was not clearly established from the evidence that this was generally the case.
- 5.287 The Commission also accepts that Mr. M's view that Grace's clothing was suitable for her activities in Day Service Provider A (or as Mr. M said, "*sufficient unto the day*") was genuinely held and correct in itself. As manager of Day Service Provider A, Mr. M's main focus was on Grace's benefiting from the activities available to her there. He did not particularly take account of her clothing style. Insofar as he did, the Commission is satisfied that Mr. M did not consider her clothing to be unsuitable and this did not give rise to his having any concern for Grace's welfare or that she was neglected. However, to the care staff whose role it was to tend to Grace's personal care and to Ms D and Ms B who encountered her later in 2008, the quality of her clothing appeared to be poor and of a basic standard. The Commission is satisfied on the evidence that these members of staff at Day Service Provider A had closer contact with Grace and a better opportunity to observe the quality and condition of her clothing.

- 5.288 The fact that Grace could not express any view on her own appearance meant that the style and quality of the clothes that she wore were chosen by Mrs. X. The Commission notes that Mrs. X herself dressed in an ordinary fashion and in a practical manner for day-to-day life in the countryside. The totality of the evidence suggested that Mrs. X made do and expended little on Grace's clothing. The Commission is satisfied that, in all likelihood, this was more and more the case as the years advanced.
- 5.289 The Commission accepts that Mrs. X's grandson and her nephew did not regard the standard or style of Grace's clothing as in any way deficient. This was not out of any disregard for Grace; rather they both considered Grace to be well looked after by Mrs. X and did not find fault with the type or standard of her dress or the manner in which Mrs. X managed her care.

Cleanliness and personal hygiene

- 5.290 The cleanliness or otherwise of Grace's clothes and her personal hygiene were important aspects to be considered in connection with her presentation. In this regard, a prominent aspect of the evidence about her clothes related to the communications between her day placement and Family X on changing, washing and returning clothes that became soiled because of an incontinence issue when Grace came off the bus in the mornings or during the day. Incidents of wetting on the bus were not infrequent. Grace regularly needed to have a shower and a change of clothes on arrival in Day Service Provider A as a result. The challenges for Mrs. X in the management of Grace's incontinence problems are reported at paragraph 3.39 above and in Chapter 2 of this Volume. It is likely to have been the case that incontinence issues tended to have a negative impact on the condition of those clothes and Grace's presentation.
- 5.291 An entirely consistent picture about the state of cleanliness of Grace's clothing did not emerge from the evidence. The Commission had accounts of Grace's appearance in the evidence reported above, which did not raise any concern about cleanliness. However, the Commission is satisfied that Grace's clothes were noticed to be stained or dirty on some occasions at the day centre, often associated with incidents of soiling or incontinence. Older stains on undergarments were observed on occasion, as if they had not been changed for a few days, and there was some evidence of stains on her outer garments. Grace's clothes were noted to give off an

old or “*musty*” odour, together with an odour associated with her incontinence or soiling.

- 5.292 Mrs. X’s evidence with respect to showering or bathing at home is reported at paragraphs 5.205 and 5.206 above. With respect to Grace’s presentation at Day Service Provider A, as reported above, at the PCP meeting with Mrs. X on 3rd July, 2009, Mrs. X was asked if there was any possibility of her being able to bath or shower Grace in the mornings, rather than the night before. Mrs. X said that she would try to do this (Grace was removed from her care two weeks later). The Commission cannot establish from the evidence as to when or how often Grace was showered at home. However, it appears from the evidence to the Commission that this PCP meeting was the first time any suggestion about Grace’s being showered at home in the morning had been made to Mrs. X.
- 5.293 At this stage, Mrs. X was 73 years old and had been caring for Grace for 20 years. It can only be a matter of speculation as to whether, had this matter been raised with Mrs. X sooner, Grace’s giving off an odour on her arrival at Day Service Provider A might have been addressed.
- 5.294 With regard to the above, the Commission notes that a pattern had developed from the early years of Grace’s attendance at Day Service Provider A that she would be regularly bathed or showered when she arrived in the morning, if there was an incident of incontinence or soiling. Grace’s baths or showers at Day Service Provider A were generally associated with these incidents of incontinence. Sometimes Grace would go to the bathroom to indicate that she wanted to get into the bath and she was regularly described as loving to play with water. The Commission is satisfied that the care staff were focused on assisting with Grace’s personal care, which they took on as part of their role and with a conscientious attention to her personal needs. Mrs. X was aware that Grace was showered or bathed in the centre through contact on issues about her incontinence and the need for her clothes to be changed. Grace sometimes wore incontinence wear for the bus journey in the morning, and there was evidence that underwear was sent in by Mrs. X in anticipation of a need for a change of clothing.
- 5.295 The Commission considers it likely, having regard to the differing impressions of Grace conveyed in the evidence over the time period under investigation, that the standard of care with respect to her presentation gradually slipped further as time

passed. This was in all likelihood contributed to by Mrs. X's advancing age, together with Grace's level of dependence and the demands of her care. Despite Mrs. X's position that Grace was "*no trouble*", the Commission considers it likely on the evidence that the demands of care, particularly as Mrs. X advanced in age, posed a significantly greater challenge than Mrs. X was ever willing to admit.

5.296 Grace's dignity clearly required that her clothing and personal appearance be attended to in an appropriate and respectful manner. This was particularly so given that she was unable to tend to her own personal care, and was entirely reliant upon the choices and the standards applied by others as to how she presented. Unlike other service users who attended the day centre (as described by Mr. M, above), Grace did not demonstrate interest in or awareness of her personal appearance. The fact that Grace was not conscious of the style or quality of her clothing did not lessen the requirement that, in the provision of her care, she be dressed to an appropriate standard and in accordance with her means. This is a matter reported upon in Chapter 5 of this Volume.

5.297 With regard to Mrs. X's position as Grace's carer, and considering the evidence related to the Commission with respect to Grace's clothing and personal hygiene in its totality, the Commission is satisfied that the evidence of her presentation over the years was such as to support a finding that there was neglect in the standard of care provided by Mrs. X to Grace in the circumstances. Having considered the definition of "abuse" provided and referred to at paragraph 1.1 above, the Commission finds that Mrs. X was negligent with regard to this aspect of Grace's care.

5.298 The Commission finds that the evidence of the old and sometimes stained or odorous condition of Grace's clothes established a neglectful approach to her personal care needs that became a set pattern over the years. Grace's overall dress and personal hygiene evidenced a lower standard of care than that to which Grace was entitled and this occurred on more than just an occasional basis.

Grace's hair

5.299 The Commission is satisfied that the evidence with respect to Grace's hair established that it was regularly seen as unkempt or untidy in appearance at her day placement. Grace did not always present in this manner and there were occasions when her hair had the appearance of being adequately attended to. The evidence

with respect to the condition of Grace's hair was not uniform. The Commission heard that it was thick, worn long, and needed a lot of attention. It was regularly described as messy, matted, greasy or ungroomed. The Commission also heard evidence of times when Grace's hair appeared clean, neatly combed, in plaits or a ponytail when in Mrs. X's care. However, considering the weight of the evidence heard as to the poor appearance of Grace's hair, the Commission is not satisfied that it was washed as regularly as Mrs. X asserted in her evidence (every second day) and the Commission finds that there was a lack of proper attention to this aspect of Grace's personal care.

- 5.300 The evidence to the Commission, critical of the condition of Grace's hair, related to the period from when she began to attend her day placement in 1995 and not to her childhood years. There was no evidence that Mrs. X tended to Grace's hair differently before and after she began to attend the day centre; however, the more detailed evidence with respect to the appearance of Grace's hair emerged in the latter period.
- 5.301 In identifying deficits in the manner in which Mrs. X took care of Grace's hair, the Commission found that the neglectful appearance of it arose from a lack of proper attention to this aspect of Grace's appearance, which progressed over time into Grace's adulthood. Mrs. X insisted on keeping Grace's hair long but then appeared to manage this by tying it back, at times with an elastic band. In this, as with other aspects of Grace's care, Grace generally appeared to be ungroomed.
- 5.302 Although not determinative of the question of whether there was neglect, it is appropriate to point out that concerns about Grace's hair did not extend to such issues as head lice or other hair or scalp conditions. In all of the evidence regarding her hair, there was nothing to suggest that such conditions had been observed, let alone been untreated, over the entire period of Grace's care investigated by the Commission.

Awareness of SEHB/HSE

- 5.303 As reported in the Second Substantive Interim Report, Mr. M saw Day Service Provider A as having a duty to bring any concerns that it had in respect of Grace to the attention of the health board and HSE social workers who had responsibility for her case. The Commission is satisfied that Day Service Provider A did have this duty. Many of the questions that arose for him and the Day Service Provider A staff in

relation to Grace's attendances at Day Service Provider A (and lack thereof), and her presentation and behaviour there could be answered on examination and enquiry. Unexplained matters of concern were the types of matters that Mr. M considered warranted reporting to the appropriate social workers.

- 5.304 The Commission accepts that Mr. M did not consider that Grace's presentation at the day centre was such as to raise a concern about neglect or to warrant reporting to the SEHB/HSE, and he reiterated that view at the Commission. The evidence, reported above, was somewhat uncertain as to the extent or the frequency with which concerns about Grace's presentation were reported or discussed within the day centre. However, the Commission is satisfied from the balance of the evidence that these matters were raised internally by care staff from time to time. While acknowledging that Mr. M was genuine in the position that he took with respect to Grace's presentation, the Commission nevertheless considers that the issues about Grace's presentation referred to in the evidence of care staff reported above could properly have given rise to concern about her care as to warrant being brought to the attention of the SEHB/HSE.
- 5.305 On the evidence provided to the Commission, the first time it was suggested to Mrs. X directly that the quality of Grace's clothing was deficient was in July, 2009 when the issue of purchasing new clothes for Grace was raised at a PCP meeting in Day Service Provider A, reported upon above. The written records maintained in Day Service Provider A and the communications between Day Service Provider A and Mrs. X over the preceding years, insofar as Grace's clothes were concerned, revolved around practical matters to do with changes of clothes because of incontinence or soiling and the return of clothes, rather than on the suitability or quality of her clothes, which was not the subject of communications with Mrs. X or Mr. X.
- 5.306 However, the Commission is satisfied that the type and general condition of clothing worn by Grace and the condition of her hair was apparent to personnel from the SEHB and HSE who encountered her over the period of 17 years while she was in the care of Family X, as reported upon in the First and Second Substantive Interim Reports. In this regard, the Second Substantive Interim Report reports, in particular, upon the failures in the management of Grace's case over the period from 1997 to 2007, including the fact that no SEHB/HSE personnel visited her placement or monitored her care at home at any point between May, 2001 and September, 2007.

- 5.307 There was no evidence to the Commission that personnel from the SEHB/HSE ever raised an issue with Mrs. X about the type or condition of Grace's clothes either before or after she started to attend Day Service Provider A and the Commission is satisfied on the evidence that the choice and provision of her clothes were matters that were left to Mrs. X to manage, unmonitored.

6. Grace's weight

Food and nourishment

- 6.1 Mrs. X remembered the first time Grace was brought to her house by Ms Greaney and that Grace was very slim. She recalled being told that Grace *"ate no solid food"* in a letter that was given to her from the Sister-in-Charge of Grace's previous school. She said that she was told *"to be careful, give her liquid and give her milk"*. She recalled that *"I told [Ms] Greaney we'd put her on solid food. She said that's the right way, change it. Give her bacon and cabbage and potatoes, give her that and give her plenty of rice. [Grace] had her breakfast, dinner, tea, tea in the evening. And say if you came in...and you had something, she'd snatch that...She was always eating, always, and she never put weight on...she was lovely. She's lovely and slim."*
- 6.2 When Grace was attending Day Service Provider A, she would get up between about 6.30 a.m. and 7.00 a.m. Mrs. X told the Commission that Grace would then have a breakfast of either cornflakes or porridge, as well as toast and a mug of tea.
- 6.3 Mrs. X said that Grace had a meal in the evening, which Mrs. X prepared. This would have been after 5.30 p.m., after her return from Day Service Provider A (when she attended). Grace also had dinner in Day Service Provider A at around 1.00 p.m. In earlier years, Mr. X, Mrs. X, and Grace ate together. If her grandson, Alpha, was there, he also ate with them. Mrs. X said that Grace loved bacon and cabbage, roast chicken and roast potatoes. According to Mrs. X, Grace ate any dinner, *"so long as it had loads of gravy on [it]"*. She said that Grace particularly liked rice pudding and that she (Mrs. X) would bake it in the oven.
- 6.4 In their evidence to the Commission, as reported above, both Alpha and Gamma described Grace as having a good appetite, and their evidence supported the evidence of her having meals with Mrs. X or the family over the years.

- 6.5 The Commission's findings regarding Grace's general health and well-being are set out below. However, speaking about Grace's weight at the time of her examination in 1992 (reported in the First Substantive Interim Report), Dr. Walsh said that Grace:

*"....presented as a slim, petite child. I suppose there are not comparative standards of height and weight for children with microcephaly as there are, for instance, in down syndrome children who have short stature, which is normal for that group. But in the context of [Grace], had a birth weight of four pounds, even though she was a full-term baby. We don't know her parental height and weight to say align her with her family size. The other issue is that she did have microcephaly, she had severe microcephaly, a very small head and say by and large 7 to 9 per cent of body weight is in the head, which would be less in this child. So if you put her on an ordinary BMI scale for the average population she would fall below that. But within her context I don't know."*³⁸

- 6.6 The fact that Grace had a healthy appetite was confirmed to the Commission in the evidence received with respect to her attendance in the day centre. Grace's diet and appetite were not matters that gave rise to concerns that she was not being properly fed at home. No concern on this topic was reflected in the notes for Grace in Day Service Provider A which were disclosed to the Commission.
- 6.7 However, the Commission did have evidence of Grace's presentation over her initial months after she started attending Day Service Provider A, set out in Mr. M's report of April, 1996, prepared for the SEHB. The evidence to the Commission was that Grace's behaviour was somewhat chaotic when she first started to attend the day centre.³⁹ This included the observation that *"when first introduced to the dining room, she would 'wolf' down her dinner and then steal the dinners of others around her"*. Mr. M reported that, by the time of his report in April, 1996 *"[Grace's] behaviour in the dining-room has reached acceptable levels"*. Grace had become more settled in the day placement by this time. Clearly the Commission cannot rule out that this behaviour was associated with her being hungry in Day Service Provider A. However, this behaviour appears to have settled down and was not a matter that was

³⁸ Dr. Walsh incorrectly referred in evidence to Grace's having a birth weight of 4 lbs. That was an error, as Grace was observed as having weighed 6.74 lbs. at birth.

³⁹ See paragraph 5.76 above, where Mr. M's report is set out.

referred to thereafter as an ongoing concern. Such observations as were made were ones that referred to Grace's appetite. She was described as "*a good eater*" and reported to eat all varieties of food. This corresponded to Alpha's evidence to the Commission and that of Mrs. X's nephew with respect to Grace's life at home with Family X. Indeed, it was of note that the only record from Day Service Provider A of any issue with regard to what food or drinks that Grace did or did not bring with her to the day service was contained in a note dated 22nd August, 2008 to the effect that a yoghurt sent in with Grace was out of date.

- 6.8 A later report from Mr. Enda McGovern, Clinical Psychologist with the Brothers of Charity, dating from December, 2008, referred to Grace's grabbing other service users' food and drinks. There was no evidence to indicate that this was because Grace was hungry or thirsty; rather, it was more that this was in the nature of a behavioural issue.
- 6.9 Grace was generally viewed in medical assessments and reports as physically well and healthy. Matters pertaining to her health and appearance are contained within reports identified in the First and Second Substantive Interim Reports and in Section 10 below.
- 6.10 At the time that Ms D first met with Mr. Smith on 17th June, 2008 and discussed Grace (reported in full in Chapter 4 of Volume 1, she raised a concern about Grace's weight. In his note of a meeting, Mr. Smith recorded Ms D as saying that she considered Grace to be "*very thin*" and to have the body of a child, weighing six stone and ten pounds. Mr. Smith noted that they estimated Grace to be five feet three inches in height, which they felt would leave her underweight in terms of body mass index. Mr. Smith also noted Mrs. X's comment to him and Ms Griffin at a home visit on 13th September, 2007 that Grace was "*so slim*." Mr. Smith noted that Ms D said that Grace was a "*good eater*" at lunch and wondered if her weight would change through regular attendance. Ms D agreed to keep Mr. Smith informed of any developments.
- 6.11 In her evidence on this issue, Ms D said that they decided to monitor the situation and to ensure that Grace was not hungry on arrival at Day Service Provider A. She said there was a short period of time when they used to offer her breakfast in the morning time, when she came in from the bus. She said that Grace did not, however, eat breakfast every morning when she was offered it. Grace woke relatively early and

travelled a considerable distance on the bus, arriving into the day centre at around 9.00 a.m. The Commission notes that other service users were offered food on arrival or that sometimes their parents would send them in with food for breakfast.

- 6.12 Ms D told the Commission that, with Grace, it was quite difficult to ascertain whether she was hungry or not on arrival at Day Service Provider A because she had a habit, when she was anxious, to take food as well. Ms D explained that, although Grace might take the breakfast, she did not always eat it and that it was not always easy to see if she was actually hungry or anxious or if she was simply not able to wait for something.
- 6.13 Ms D said that Grace had a lunch every day in Day Service Provider A and that she ate whatever was put in front of her. She did not recall Grace's weight increasing considerably over the period of time that she attended the day centre more regularly, from the summer of 2008 onwards.
- 6.14 On the question of whether Grace's weight would be likely to change with more regular attendance at the day centre, Ms D said that she did not recall that it increased considerably. Ms D told the Commission that, since Grace's admission to her residential placement, her weight had gone up to over eight stone. She added, however, that Grace was also taking two antipsychotic medications, one of which would cause quite significant weight increase.

Findings on Grace's weight

- 6.15 The evidence to the Commission did not establish that there was neglect of Grace in the provision of food and sustenance to her over the years she lived with Family X. Overall, the evidence supports a finding that her requirements in this regard were met by Mrs. X. The evidence was that Grace ate her meals at home as part of the family and there was also evidence that she was occasionally taken out to eat in restaurants.

7. Placement for schooling suitable to Grace's needs

Preliminary - First Substantive Interim Report

- 7.1 The issue of the absence of school provision of any kind for Grace when she was a child in the care of the SEHB and the Commission's findings on this issue, have been

fully reported in the First Substantive Interim Report. The extensive and detailed history and the Commission's findings on this issue in that report should be read here for an understanding of the facts established about this important aspect of Grace's care. In this regard, the following paragraphs are by way of bare summary of those findings.

- 7.2 When Grace was placed in foster care with Mrs. X, no arrangements were put in place to provide her with an education suitable to her abilities and needs, although in a letter which Ms Greaney wrote to Grace's former foster mother on 4th May, 1989, she said that she had applied for Grace's admission to a school for "special children" in Waterford. No documentation relevant to that matter or to any follow-up in relation to it by the health board appeared in the records disclosed to the Commission.
- 7.3 In Chapter 5 of the First Substantive Interim Report, the Commission reported on the fact that the SEHB did not arrange for Grace to attend any special school or day facility over the time that she came into the care of the SEHB and was placed into foster care with Family X in February, 1989. The first time Grace attended such a facility (Day Service Provider A) was at the age of 16 in 1995. While Grace had attended a special school for a period when she resided in the Eastern Health Board area (before the age of 10), as reported in Chapter 4 of the First Substantive Interim Report, Day Service Provider A was the first service that she had been sent to by the health board since she had been placed in foster care in the South East.
- 7.4 As reported at paragraph 25.17 of the First Substantive Interim Report, although the boarding out contract (described in Chapter 4 of that report) placed an obligation on a foster parent to ensure that a child in his or her care attended school, the Commission is quite satisfied that the fundamental responsibility to source and arrange for Grace's attendance at a facility suitable to her needs was that of the health board and not the foster parent. The health board was clearly best placed to do so. As reported in Chapter 5 of the First Substantive Interim Report, the Commission is satisfied that it was the health board's responsibility to identify a school or placement suitable to Grace's needs, to seek to have her admitted there and, in the event of her admission, to assist in putting in place the supports necessary to enable her attendance there.

- 7.5 At the beginning of 1995, Grace was 16 years of age and had been living with Family X in the south east for nearly six years. During this time Grace had no school placement and spent most of her time at home with Mrs. X.
- 7.6 In the Commission's First Substantive Interim Report, which should be read with this Chapter, the Commission has reported upon the lack of provision of an appropriate educational placement for Grace and the nature and extent of any efforts to source any such placement for her actually made by officers of the health board charged with her care, when she was a foster child in the care of the SEHB.⁴⁰ While the responsibility to source and arrange for Grace's attendance at a facility suitable to her needs was that of the health board and not the foster parent, the Commission also finds that Mrs. and Mr. X themselves did not have regard to or recognise the potential benefits of special schooling or a day placement for Grace during her childhood years, and never sought to press for such a placement on her behalf. The Commission considers that this attitude was based on a misguided and unenlightened view that Grace's level of disability was such that she did not have any capacity to participate in or to derive any benefit from such schooling.
- 7.7 As reported in the First Substantive Interim Report, it is important to emphasise that no reliable finding can be made by the Commission on the extent to which Grace might have attained enhanced life skills or self-care skills or broader life experience had she attended a daytime educational facility or been in a residential placement between the ages of 11 and her seventeenth year. However, the potential to realise such gains or skills in an appropriate structured setting was the very reason why the health board had considered at the meeting in October, 1989 that it would be in Grace's interests to attend a residential facility. The Commission considers, on the evidence, that the health board fundamentally failed to provide Grace with such a potential opportunity over this period. While the extent of skills or gains that Grace may have attained had she had such a facility in daytime or residential placement cannot be determined, the Commission is satisfied that, in all likelihood, Grace would have derived benefits of that kind from an appropriate structured setting. Indeed, the evidence in respect of the improvements in Grace's life on attending Day Service Provider A and being exposed to a variety of activities and the company of her peers from September, 1995 onwards is reported upon in detail in Chapter 6 of the Commission's First Substantive Interim Report.

⁴⁰ See paragraphs 25.15 to 25.20 of Chapter 5 of the Commission's First Substantive Interim Report.

- 7.8 The circumstances whereby a place was eventually sourced for Grace by the SEHB at the day centre for adults with disabilities, Day Service Provider A, and which Grace began to attend in September, 1995, have been reported upon in considerable detail in the First Substantive Interim Report. The significant difficulties encountered by Grace in attending a day centre for the first time at the age of 16 are reported there also. The background to the establishment of that centre, its origins and its aims, functions and activities are also fully reported in the First Substantive Interim Report. Reference has also been made to them in this Chapter.

8. Grace's level of attendance at day placement

Introduction

- 8.1 The issue of Grace's absences from her day placement in Day Service Provider A over the years from when she started there in September, 1995, was an important one for the Commission to investigate. The evidence considered by the Commission on this issue included the evidence as to the reasons for Grace's absences, communication between Mrs. and Mr. X and Day Service Provider A with respect to Grace's attendance, and the communications between Day Service Provider A and SEHB/HSE personnel about the level of Grace's non-attendance at her day placement.
- 8.2 This Section reports upon the facts established by the Commission regarding the extent of Grace's absences from her day placement, together with the reasons for such absences. The knowledge of the SEHB and the HSE and communications between Day Service Provider A and the SEHB and the HSE with respect to Grace's pattern of absences from her day placement, have also been reported in the Second Substantive Interim Report. These aspects are referred to further below.
- 8.3 This Section also considers the potential impact on Grace of a pattern of increasingly sporadic attendance at her day placement in the years up to 2007.

Grace's absences from Day Service Provider A

Preliminary

- 8.4 The background to the establishment and operation of Day Service Provider A has been reported in Chapter 6 of the First Substantive Interim Report,⁴¹ which should be read in conjunction with this Chapter. Aspects of Grace's life in Day Service Provider A are reported in the First and Second Substantive Interim Reports and the role of Day Service Provider A, as a facility to help adults with learning disabilities, has been reported in the Second Substantive Interim Report. The nature of its work and activities is further reported in Chapter 6 of this Volume.
- 8.5 The day centre was a service that was attended voluntarily by adults with intellectual disabilities or (as in the case of Grace) whose attendance was facilitated, in order that they might benefit from the facility and the activities and services it provided. The persons who availed of the facility did so by choice. Mr. M told the Commission that Grace was the first person under 18 years of age who had attended Day Service Provider A at that point.⁴²

Records of attendance

- 8.6 The Commission is not in possession of an accurate, definitive record of Grace's attendances or absences from Day Service Provider A during the period from 1995 to 2007, but it saw some records kept by Day Service Provider A which were of assistance in estimating the duration of these absences. Records from 1995 to 1999 did not provide the Commission with any clear picture of Grace's absences during that time.
- 8.7 Furthermore, due to a six month gap in the records, it was difficult to establish with any certainty the level of Grace's absences in the year 2000.
- 8.8 As already noted, the figures reported upon have been derived from incomplete attendance records and accordingly are an approximation only. From the documentation provided, it is apparent that Grace's attendance level varied and that, throughout the years, there were significant periods of absences. The Commission is

⁴¹ See paragraphs 3.9 to 3.22 of Chapter 6 of the First Substantive Interim Report.

⁴² This matter is reported upon at paragraph 5.14 of the Second Substantive Interim Report.

satisfied that there were significant periods of non-attendance on her part at Day Service Provider A.⁴³

- 8.9 Mr. M's report of April, 1996 (referred to above) with respect to Grace's initial period attending the day placement is reported upon in the First Substantive Interim Report. At the time that the 1996 report was commissioned, having detailed Grace's initial difficulties in adjusting to attending the day centre, Mr. M reported that "[Grace] *is in good health, has been absent only occasionally with the 'flu'*".
- 8.10 The Commission is satisfied that Grace's pattern of attendance was haphazard and sporadic and that it declined considerably over the years until it increased again in the summer of 2008.⁴⁴

Evidence of absences

Mr. M's evidence

- 8.11 Mr. M, Manager of Day Service Provider A until March, 2008, recalled in evidence that when Grace was absent, notes would pass back and forth between Day Service Provider A and Mrs. X as to the reason she was not in. He recalled "*ailments rather than illness*" as being the primary factor in Grace's non-attendance. Mr. M said that Grace was prone to colds and recalled being told this by Mrs. X. Mr. M also recalled from his own experience that Grace did suffer from colds.
- 8.12 Mr. M's recollection of Grace's attendance was that it was "*sporadic*" and "*hit and miss*." Reflecting on the position at the Commission, he said that he had not noticed a gradual decline in Grace's attendance and that he did not analyse her attendance to that extent. Mr. M said that, if Grace was absent, it was not necessarily brought to his attention by staff members but that he did notice when she was not there.
- 8.13 Mr. M said that, in general, if Mrs. X gave an explanation for Grace's absence, it was accepted at face value.

⁴³ See paragraph 19.1 of the Second Substantive Interim Report for detail of Grace's absences from Day Service Provider A.

⁴⁴ Details of Grace's increased attendance in 2008 can be found in Chapter 4 of Volume 1.

Mr. M in conversation with Mr. X

- 8.14 Mr. M also had a memory of many telephone calls with Mr. X in earlier years. He said that the reasons for the calls were *“many and varied”*. He said that these telephone calls could have been about clothes, or due to Mr. M’s telephoning (when Grace was absent) to see where she was, what was wrong with her, and to find out when she would be returning to Day Service Provider A. Mr. M said that, on other occasions, Mr. X telephoned to say that Grace had gone to the doctor or that she was having her period and was not feeling well. Other times, Mr. M told the Commission that Mr. X would telephone to inform him that Grace had been barred from travelling on the bus, or that she was banging her head going home on the bus and was sore and that Mrs. X was going to keep her at home for a few days.

Mr. M in conversation with Mr. Smith

- 8.15 During his first telephone call with Mr. M on 16th August, 2007, Mr. Smith recorded that he told Mr. M that he *“needed to feedback to [Grace’s] mother and to assess the status of [Grace] as a vulnerable adult”*. As regards Grace’s attendance at the day centre, Mr. Smith noted from this conversation with Mr. M that Grace was meant to be attending the centre three days *per week*, but that *“sometimes [Mrs. X] says that [Grace] is not in the right mood to go on the bus”*.

Grace’s absence on Wednesdays and Thursdays

- 8.16 In a note of a meeting with Mr. M on 22nd August, 2007, Mr. Smith recorded that “[Mr. M] said [Grace] continues to attend the centre but is often absent [Wednesdays] and [Thursdays]. This is because, according to [Mrs. X], on these days the bus agitates [Grace] the most.” Mr. Smith noted that “[s]he also misses time as [Mrs. X] says that she suffers from coughs and chest infections.”
- 8.17 When asked about this, Mrs. X told the Commission that she did not know why Grace tended to be absent on Wednesdays and Thursdays. She said that she noticed on Mondays and Tuesdays that Grace was *“okay”* but that, by the time it got to Wednesday, the bus driver would not take her and she had to be kept at home. Mrs. X said that, on Tuesday evenings, the bus driver would *“blow the hooter”* outside her house and say to Mrs. X that he was not taking Grace, that she was *“banging”* and

running up and down the bus and that he could not cope. Mrs. X. said that this situation of the bus driver's refusing to take Grace went on for a long time.

- 8.18 Mrs. X told the Commission that the bus driver would tell her that he was *"really scared"* of taking Grace on the bus when she was banging her head so much. Mrs. X recalled that Grace used to go up and down the bus and bang her head and that *"several times [Grace] came home with lumps"*. She said that, on one occasion, she asked two specific people on the bus *"is she that bad?"* and they told her *"yeah, we tried to stop her and we can't"*. She said that the driver would have to pick Grace up off the floor of the bus when she fainted. Mrs. X said that the bus driver told her that he wanted a helper and she thought that they tried hard to get a helper to travel on board the bus. The Commission is satisfied that the evidence of Grace's difficulties on the bus, as relayed by Mrs. X, is substantially correct. Difficulties that Grace experienced on the bus are referred to above at Section 3 and are reported upon in further detail in Chapter 2 of this Volume.

Mrs. X's "reluctance" to let Grace attend day service

- 8.19 Mr. Smith also recorded that *"[Mr. M] will speak to [Mrs. X] on the telephone regularly and for upwards of an hour at a time. [Mrs. X] will question [Mr. M] at length about anything that she thinks is unsatisfactory. I asked [Mr. M] if he thought that [Mrs. X] was reluctant to let [Grace] use the centre, and if essentially this had always been the case. [Mr. M] said this was true. He added though that he regarded [Mrs. X] as essentially a loving person."*
- 8.20 Mr. M recalled speaking to Mr. Smith on 22nd August, 2007 about Mrs. X's initial reluctance for Grace to attend the day centre. Mr. M did not believe, however, that he would have been as emphatic as Mr. Smith's note recorded in relation to Mrs. X's reluctance at the time of their meeting, as he could not say whether or not Mrs. X was reluctant at that time.
- 8.21 Mrs. X did not agree that she was reluctant to allow Grace to use the day centre. She said that that was *"wrong"* and that she was happy for Grace to attend Day Service Provider A. Mrs. X said that she was not happy about it before Grace first went but that, when she did start to go, she was happy because Grace was happy. She said that she thought that Day Service Provider A was of benefit to Grace, in that it occupied her mind with the others there.

- 8.22 In relation to Grace's absences, Mr. M explained that they were concerned in Day Service Provider A *"in the sense of we would like [Grace] back kind of thing because she was going to regress"*. Mr. M said that telephone calls would be made to Mrs. X and there would be an explanation for Grace's absence. As outlined above, he said that, in general, if Mrs. X gave an explanation for Grace's absence, that was accepted. He referenced the good standing Mrs. X had in the community and said that nothing happened that caused him to revise his opinion of Mrs. X or the care she was providing for Grace. Mr. M told the Commission that the explanations that were given in respect of Grace's absences were believable. In relation to communication with Mrs. X regarding Grace, Mr. M said that *"[w]e were being honest with Mrs. [X] and we felt she was being honest with us"*.
- 8.23 Mr. M said that there was a regression every time Grace came back from an absence, describing it as though the staff had *"to climb the mountain again"*. Mr. M said that, after such absences, they had to walk Grace through her routines again and remind her of toileting times and to sit at the table. He said that, when she was like that, Grace might have screamed or hit her head and that the head-banging or the stripping of her clothes *"could spring out of anywhere"*.
- 8.24 In February, 1999 Ms Leyshon contacted Mr. M by telephone to introduce herself as Grace's new key worker and to have a discussion about Grace. She kept a note of the conversation. Her note recorded that Mr. M told Ms Leyshon about how Grace was getting on and about her absences from time to time, including a recent absence in January, when she had been out for a month with a cold. Mr. M felt that that was a long time. Mr. M told the Commission that his concern about Grace's absences arose because they were proud of the work they had done with her since she began in Day Service Provider A and *"didn't want [her] to be going backwards"*.
- 8.25 Ms Leyshon recorded that Mr. M told her that consistent attendance was beneficial for Grace and that there had been some regression in her behaviour when she returned from a long absence. Mr. M wanted to ensure that Grace's placement in Day Service Provider A continued.

CW2's evidence

- 8.26 CW2 gave evidence that everyone at Day Service Provider A was aware of Grace's long absences and that the staff recorded the absences in their notes. She said that

Grace was often out for long periods of time, maybe a month or two and that, sometimes, it would be a random few days or weeks. She recalled how there was an attendance record in each room, and that, later, there was one record for the entire of Day Service Provider A. However, she did not think that attendance records were completed every day and that they could be relied upon as being accurate.

- 8.27 CW2 recalled that the bus driver would sometimes pass on a message to Day Service Provider A from Mrs. X as to why Grace would not be coming in. CW2 cited examples of such messages, such as Grace's banging her head or stripping off her clothes or being bold. CW2 also recalled that Mr. and Mrs. X sometimes telephoned Day Service Provider A to inform them that Grace had a cold or the flu and that she was being kept at home. She also recalled that they would sometimes telephone simply to say that Grace had been bold and they were not sending her in to Day Service Provider A. CW2 recalled that sometimes Mrs. X telephoned and, at other times, Day Service Provider A had to telephone her to find out why Grace was being kept at home.
- 8.28 CW2 also referred to the problem of Grace's regressing and noted that, while they did "*great work*" with her when she was at Day Service Provider A, when she came back after absences of one or two months, they had to "*start [their] work all over again with her*". CW2 said that Grace was "*quite difficult*" to manage for the first number of days, until she settled back down again.
- 8.29 While CW2 (who worked in Day Service Provider A with Grace from 1997, and was still working there at the time she gave evidence to the Commission) said that Grace regressed after long absences, CW1 (who worked there for three years, 1997 to 2000) told the Commission that she was not in a position to say whether she had seen any "*great setbacks or progression*" in Grace during her (CW1's) time working at Day Service Provider A.

CW5's evidence

- 8.30 CW5, Programme Assistant at Day Service Provider A between 2004 and 2007, also recalled telephoning Mrs. X to know why Grace was absent or to ask when Grace would be back at Day Service Provider A. She said that, a lot of the time, Mrs. X told her that Grace was sick. CW5 said that she wanted consistency for Grace and that

she telephoned to encourage Mrs. X to send Grace to Day Service Provider A and to reiterate its value for Grace.

- 8.31 CW5 said that she found Grace's long absences from Day Service Provider A concerning. In her evidence, she observed, however, that Mrs. X probably did not see it like that. She thought that Mrs. X's perception, and what she recalled Mrs. X as saying, was that Grace had to go on the bus journey to and from Day Service Provider A, all for the sake of a couple of hours. CW5 believed that Mrs. X saw the bus as a difficulty for Grace. She also had a vague recollection of the other service users saying that Grace was bold on the bus.
- 8.32 CW5 also told the Commission that she was afraid that, when talking with Mrs. X, she would say something wrong which would lead Mrs. X to keep Grace out of Day Service Provider A for longer. Although CW5 found Mrs. X pleasant, she said that she found it challenging to communicate with her. She felt that Mrs. X was making all the decisions for Grace and that Grace was not getting a choice. She did not think that Mrs. X understood the value of the day service for Grace. She said that it was very difficult to get Mrs. X to see the importance of sending Grace in, pointing out how much Grace enjoyed her participation in swimming and in the different programmes. She thought that this was not really received by Mrs. X.

Mrs. X's evidence

- 8.33 Mrs. X's evidence outlined the main reasons for Grace's absences and these, broadly speaking, fell into four main categories, as follows:
- illnesses;
 - issues with Grace's bus travel;
 - incontinence; and
 - company for Mrs. X at home.
- 8.34 On occasion, absences arose from a combination of the above four reasons.

Illnesses as reason for absences

- 8.35 The illnesses referred to as reasons for Grace's absences were mostly common ailments in the nature of coughs, colds, chest infections or sore throats. These included the occasions when Grace was taken to her general practitioner as reported in Section 10 below and other occasions when she was treated at home.
- 8.36 Clearly, the Commission could not establish the facts with respect to each time that Grace was not in attendance at Day Service Provider A on the stated basis that she was sick. There was no evidence that reasons for Grace's absences were questioned at the time they were given.
- 8.37 At a meeting in Day Service Provider A on 21st July, 2008 attended by Mrs. X, Ms C, Director of Nursing at the local voluntary association since 2007, and Ms Margaret Browne, Coordinator of Disability Services with the HSE, at which a residential placement for Grace was offered, Mrs. X, *inter alia*, attributed Grace's poor attendance at Day Service Provider A to transport reasons and pointed out that Grace's attendance had recently improved. She said that Grace's incontinence was worse when attending the day service. With regard to concern expressed at the meeting about social isolation (in the context of the offer of a residential placement), Mrs. X's opinion was that Grace was not very aware of that and she also said that Grace had always been very happy in her home. In an email reporting back on the meeting to her colleagues, Ms Browne recorded: "*We did not deny this, however, we did point out that we had concerns including poor attendance at [the] day centre...*"⁴⁵
- 8.38 When Mrs. X was also asked at the meeting on 21st July, 2008 about taking Grace to the general practitioner, she replied that she only took Grace to him when she was sick. When she was asked at that meeting whether she had ever taken Grace to the general practitioner when Grace missed her day service, Mrs. X said that she did not consider this as being sick, as Grace only had a cold.

Issues with Grace's bus travel as reason for absences

- 8.39 Mrs. X said that Grace was not easy to manage and that she never stopped jumping and banging but that she coped because she (Mrs. X) "*hadn't anybody else*". Mrs. X

told the Commission that it was a good thing that Grace attended Day Service Provider A as she had the opportunity to do activities that she liked and which were beneficial to her.

8.40 Mrs. X told the Commission that Grace was happy at home. She agreed that, when Grace did not go on the bus, this was either because she would not let her, or because the bus driver would not take her. The difficulties with bus travel for Grace, including the evidence of Mr. M on this topic, have been reported in Section 3 above and in Chapter 2 of this Volume, which should be read in conjunction with this chapter.

8.41 The Commission is satisfied from the evidence considered on this issue that the bus journey to and from Day Service Provider A, which took approximately one hour each way, regularly presented a very challenging environment for Grace as a person with a severe intellectual disability and the associated issue of incontinence.

Incontinence issue as reason for absences

8.42 A related issue to Grace's difficulty regarding bus travel was her incontinence. The Commission considers that, in all likelihood, Grace's episodes of incontinence on the bus and in the day centre contributed to Mrs. X's sometimes keeping her at home. Mrs. X was clearly concerned about Grace's incontinence throughout her engagement with the day centre and, having managed it relatively well at home, where she could take Grace to the bathroom, she was concerned when it occurred on the bus or in the day centre, and when Grace began wetting again. The impact of this incontinence problem and the extensive communication between Mrs. X and Day Service Provider A on this topic over the years have been reported upon above and in Chapter 2 of this Volume.

Company for Mrs. X at home as reason for absences

8.43 Mrs. X told the Commission that she also kept Grace at home with her for company. Recalling the period from 2002 to 2006, Mrs. X told the Commission that, by this stage, her grandson was attending school and her husband was deceased. As a

⁴⁵ Email dated 21st August, 2008 from Ms Browne to Mr. Pat Walsh and Mr. Dermot Halpin, the Acting General Manager and Local Health Officer in Waterford Community Care respectively.

result, Mrs. X was at home on her own for extensive periods. The evidence to the Commission suggested that Grace was almost always in Mrs. X's company when not at her day placement. The evidence provided to the Commission with respect to Grace's day-to-day life is considered in Chapter 6 of this Volume.

Grace's level of attendance increases

- 8.44 It was not until July, 2007, when Mr. Smith began to review Grace's case, that her irregular attendance at her day placement was picked up as a concern within the HSE. The management of Grace's case within the HSE from this time is reported in Volume 1.
- 8.45 The Commission heard evidence that, after Ms D spoke to Mrs. X about the matter in May, 2008, she agreed to increase Grace's attendance at Day Service Provider A to five days *per* week. As reported upon in Chapter 4 of Volume 1, Ms D had telephoned Mrs. X to introduce herself as the new manager of the day service and to encourage Mrs. X to increase Grace's attendance. In the course of that conversation, Ms D recalled that Mrs. X had referred to Grace's banging her head on the bus as the reason for her not attending full time. Mrs. X complied with Ms D's request, and ensured that Grace was placed on the bus that collected her from her house. This situation continued until Grace was removed from Mrs. X's care in July, 2009.
- 8.46 Notwithstanding that, as has been noted above, Grace's absences from Day Service Provider A remained something that the local voluntary association and the HSE were alert to when Ms C and Ms Browne met with Mrs. X at the day centre on 21st July, 2008.

Findings on Grace's level of attendance at Day Service Provider A

- 8.47 The Commission finds that Mrs. X's actions in not ensuring that Grace attended the day centre more regularly and more consistently, were such as to establish neglect on her part with regard to this aspect of Grace's well-being, having regard to the following.
- 8.48 The many benefits to Grace of attending her day placement are reported in Chapter 6 of this Volume. The placement exposed her to a variety of activities from which she derived enjoyment and fun and also provided her with opportunities to pick up some

new skills within her competence. It brought her into a new environment and into contact with a broader variety of people. It gave her an opportunity for socialisation and was an outlet from home. When Grace was not able to attend her placement, she did not have these benefits. As reported above, Grace's personal care also benefited from the attention she received from the care staff at Day Service Provider A.

- 8.49 One of the main concerns of the staff of Day Service Provider A regarding Grace's long absences was that she regressed and lost her routine at the day centre. Grace's history of difficulty in adapting to change is recorded throughout the Commission's reports and is detailed in the First Substantive Interim Report. Mr. M told the Commission that there was a regression every time Grace came back from an absence, describing it as having "*to climb the mountain again.*" He recalled having to walk Grace through her routines again, such as toileting and how to sit at the table, and how Grace might have screamed or hit her head. Mr. M recalled that head-banging or stripping off her clothes was behaviour that could spring out of anywhere and he said that he was conscious of the risk of that happening.
- 8.50 Mr. M explained that the day centre staff were proud of themselves for what Grace had achieved with them. They did not want her to go backwards and so they worried she would not come back. In his discussions with Ms Leyshon in 2001, Mr. M had told her that consistent attendance was beneficial for Grace and that there had been some regression in her behaviour when she returned from a long absence.
- 8.51 CW2, who worked with Grace from 1997 to 2009 and beyond, gave similar evidence in relation to this problem. She said that every time Grace came back to Day Service Provider A after an absence, she had regressed and they had to start all over again with her. CW2 told the Commission that Grace was quite difficult for the first number of days after her return until she settled back down again.
- 8.52 CW1, who worked with Grace for three years from 1997 to 2000, told the Commission that she was not in a position to say whether she had seen any "*great setbacks or progression*" in Grace during her time working at Day Service Provider A.
- 8.53 Although this regression was not capable of precise measurement, it was clearly an issue that was significantly contributed to by inconsistency of attendance. Given

Grace's level of disability, the establishment of a new routine for her was always a significant challenge.

- 8.54 The Commission found that, although many absences from her day placement over the years could reasonably be attributed to occasions when Grace was sick, or to her difficulties with travelling on the bus, these reasons did not account for the increasing and lengthy periods of absence over the years from 1995 up to the summer of 2008, from which point there was a marked increase in her attendance.
- 8.55 With regard to absences due to sickness, the fact that Grace sometimes suffered common-or-garden ailments in the nature of coughs, sore throats, and colds was supported by the evidence of medical history as reported in Section 10 below. The Commission also accepts that Grace was sick at times with such ailments, even though she was not taken to the doctor. However, the periods of time during which Grace was absent were longer than might normally have been expected on account of such ailments. Grace's general health was good. The Commission considers it likely on the totality of the evidence that the assertion that Grace was sick, or continued to be sick, was used as an excuse at times for absence when this was not, in fact, the case.
- 8.56 There were also occasions when the day centre was told that Grace was kept home because she was being "*bold*". The Commission cannot at this stage establish or examine the basis for this reason when it was given.
- 8.57 The Commission finds that the need for Grace to travel a distance from her home to Day Service Provider A by bus was a significant factor behind some of her absences. The Commission considers that Grace would undoubtedly have found the long inward and outward journey with a number of other service users on the bus to be physically exerting. It is accepted that Mrs. X's issues about her travelling on the bus were based on real concerns. The Commission is also satisfied on the evidence that there were days when the bus driver would not take Grace on the bus because of behavioural issues. Issues with regard to how Grace fared on the bus were factors that caused difficulty for both the bus driver and for Mrs. X, and undoubtedly contributed to her absences.
- 8.58 The Commission accepts that Mrs. X was also concerned about incontinence issues occurring when Grace was on the bus and at the day centre. The Commission is

satisfied that this issue accounted for her keeping Grace at home on at least some occasions.

- 8.59 However, apart from the above, the Commission finds that many of Grace's absences, including for prolonged periods, occurred because Mrs. X wanted Grace to remain at home with her, for company. Mrs. X's overall attitude was that Grace was better off at home with her and regarded her attendance at the day centre as less of a priority. In this respect, although Mrs. X did have an awareness of the potential benefits for Grace of attending the day centre, the Commission finds that she did not in fact place sufficient value on how the day placement might benefit her. In this regard, the evidence pointed to a pattern of lengthening periods of absence over the years up to the summer of 2008.
- 8.60 The Commission considers it likely that getting Grace up and dressed on time for the bus in the morning would have entailed a good deal of effort on both Mrs. X's and Grace's part and that the reality of the day-to-day effort in this regard had some influence on the extent of Grace's absences.
- 8.61 Apart from the times that Grace was not permitted to travel on the bus, Family X, and primarily Mrs. X, decided whether or not Grace would attend the day centre. Clearly, attendance there was not a matter within Grace's control but it is clear from the evidence that she benefited significantly from the time she spent there.
- 8.62 As reported in detail in Chapter 1 of Volume 1, the HSE had re-engaged with Grace's case and visited her placement with Mrs. X in September, 2007 after a gap of six years during which there had not been any visits to Grace or any SEHB/HSE monitoring of that placement. It was in response to Ms D, the newly appointed manager at Day Service Provider A in 2008, that Mrs. X then agreed to increase Grace's attendance and to send her into the day centre five days a week thereafter.
- 8.63 As reported upon extensively in Chapter 10 of the Commission's Second Substantive Interim Report, the Commission is satisfied that the SEHB was well aware from Day Service Provider A of the concern about absences from Grace's day placement, since the social workers and Coordinator of Disability Services involved in Grace's case up to 2001 knew of this issue. These absences were raised by Mr. M with Mrs. X and with the health board, Mr. M's concern being to ensure that Grace would not regress or lose the benefits of regular attendance at the day centre. As reported in

Chapter 10 of the Second Substantive Interim Report, the evidence was uncertain on the issue of whether absences were specifically brought to the attention of Mr. Carsten Kohl, HSE Social Worker for Adults with Learning Disabilities, who was in post from June, 2002 to 2006, and the Commission cannot establish whether or not this occurred.

- 8.64 It is a matter of speculation as to whether a conversation with Mr. Kohl, if it had occurred, would have prompted any review of Grace's case by the SEHB or the HSE having regard to the fact that these absences were not a new feature. As established in the Commission's Second Substantive Interim Report, Grace's case had fallen through the cracks from a SEHB perspective from mid-2001. There was no follow-up, enquiry about, or review of her case by SEHB or HSE personnel up to July, 2007, when her case effectively resurfaced. There was no evidence that SEHB or HSE personnel ever engaged with Mrs. X about Grace's attendance at Day Service Provider A. The failings on the part of the SEHB and the HSE in their duty to Grace over the above period have been reported upon in the Second Substantive Interim Report.

9. Grace's dental health

Introduction

- 9.1 Grace's oral hygiene, together with the care of her teeth and gums, was a focus of the Commission's investigation as to whether or not she was subjected to physical neglect during the years that she was in the care of Family X.
- 9.2 The care of Grace's teeth was an issue from her early days. Grace was unable to brush her teeth and, as a consequence, she was unable to attend to her own dental hygiene.
- 9.3 In January, 1989, the Sister-in-Charge of the special school attended by Grace in the Eastern Health Board area, prior to her foster placement with Family X, prepared a report on Grace. She noted in that report that "*teeth need to be checked*" and self-help matters, such as brushing teeth, were "*still unreliable*".
- 9.4 In 1989, a psychologist prepared a report on Grace in which she referred to Grace's capacity to care for herself. She stated that Grace, who was 10 years of age by that time, "*brushes [her] teeth with supervision*". The Commission is satisfied, having

regard to the evidence heard with respect to Grace's care at home and in Day Service Provider A, that Grace was not capable of brushing her own teeth, with or without supervision, and that the above note cannot therefore be an accurate reflection of her capacity to self-care in this respect. Grace always needed to have her teeth brushed by someone else.

- 9.5 The above reports were in the possession of the SEHB at the time that Grace was placed with Family X. There was no evidence of any arrangement having been made by the health board to have her teeth checked at that stage, before or indeed after she was placed into Mrs. X's care in February, 1989.
- 9.6 During the course of their evidence, a number of witnesses, particularly care workers who worked at Day Service Provider A, made reference to the condition of Grace's teeth and gums and to the attempts to brush her teeth at Day Service Provider A. Much of this evidence is referred to from time to time in Section 5 above.

Brushing Grace's teeth

Mrs. X

- 9.7 Mrs. X was the person who attended to Grace's teeth at home. In her evidence on this topic, Mrs. X said that Grace did not like having her teeth brushed and resisted it on a daily basis. Her evidence was that it was very difficult for her to brush Grace's teeth. Mrs. X said that, although she was not always successful, she tried to brush them every morning. Her evidence was that she was able to get the job done. Whether she did it well or not she did not know, but she was happy with it. Mrs. X said that to open Grace's mouth was very difficult and that Grace jumped and did not want to be touched, which Mrs. X attributed to her sore and bleeding gums. When asked how she would go about brushing Grace's teeth, Mrs. X said that she *"just got the brush and brushed them."*
- 9.8 Mrs. X described how Grace would often scratch her gums with her toy keys, which she carried with her all the time. Mrs. X also gave evidence that Grace never stopped banging her teeth and her ears.
- 9.9 As reported below, Dr. Maura Haran, Senior Dental Surgeon, Special Needs, HSE, who first saw Grace on 8th October, 2008, gave evidence that she advised Mrs. X to

get an electric toothbrush and instructed her in its use. Mrs. X told the Commission that she found it easier to brush Grace's teeth with the electric toothbrush as there was less resistance and she got a better job done. Her evidence was that she used the electric toothbrush both morning and night. However, she said that Grace did not like this any more than brushing by hand. From the evidence with respect to visits to Dr. Haran in 2008, referred to below, it appears likely that an electric toothbrush was only used for the first time at that point.

Alpha

9.10 Alpha had no role in Grace's personal care; however, he was aware that brushing her teeth was a problem and that it was a difficult task to perform. He also recalled that when there was an attempt by Mrs. X to brush her teeth, Grace could scream, like she did not want it to be done. He was, of course, not always in the house when Mrs. X was attending to Grace.

9.11 Alpha also recalled that Grace could be at the table having her dinner and could start tapping her teeth with her toy keys. His evidence was that, at times, Grace would make her gums bleed as a result of tapping them off her teeth.

Gamma

9.12 Gamma did not have any evidence to offer on the subject of the brushing of Grace's teeth, saying that he was generally out at work when that would have been happening. He did recall that Grace *"...used to have keys and she'd be prodding herself and Mrs. [X] used to get on to her, [Grace] used to stick them in her teeth..."* Gamma recalled that Grace's gums bled a little bit. In this regard, he said that he thought that *"it was just probably a habit she had."*

Visits to the doctor – teeth and gum issues

Preliminary

9.13 Dr. F was the local general practitioner and Grace's general practitioner throughout her time living with Family X. He retired in 2011. His son, Dr. G, also worked in the practice from February, 2005.

- 9.14 Dr. F gave evidence of Grace's being taken to see him by Mrs. or Mr. X on a number of occasions over the years for teeth and related gum issues. Dr. F did not have an independent memory of Grace's visits for the particular dates identified from his records, observing that "[t]here is no way I could remember back 30 years ago." He had not seen Grace for approximately 18 years by the time he gave his evidence and his memory of specific visits was predominantly based on what was written in his notes.
- 9.15 From his records, Dr. F said that Mrs. X brought Grace into the clinic most of the times that she attended. Mr. X also brought Grace on occasion and there were also occasions when one or other of them would telephone the surgery if Grace was unwell.
- 9.16 Dr. F knew that Mrs. X was a foster carer and he thought that the relationship between her and Grace was "very good". He said that Mrs. X was caring towards Grace when she was in his surgery and that it seemed to be a normal relationship. He said that, like most of his patients, Mrs. X behaved in a way that he considered normal when dealing with a vulnerable child, adding that he always regarded Grace as a child even when she became an adult. Asked if he was satisfied that she was taking good care of Grace, Dr. F said "[s]he seemed to be, to me anyway. Absolutely, I had no doubts."

General practitioner visits

- 9.17 Dr. F's earliest notes recorded that Grace was taken to see him on two occasions in 1990 for teeth- or gum-related matters.
- 9.18 His first record of a visit was on 31st May, 1990. Dr. F examined Grace and, with respect to her teeth, he noted "[t]eeth crowding - Dentist." Dr. F interpreted this as denoting that he would have referred Grace to the local community dentist (now deceased). He told the Commission that "*I did initially and then I obviously never thought about it again I presume*".
- 9.19 Mrs. X did not remember this visit. The Commission was unable to establish whether Grace was, in fact, referred to the local community dentist by Dr. F following this appointment. There were no records evidencing this available to the Commission.

Nor was there any evidence from Mrs. X of Grace's undergoing any dental or orthodontic procedures around this time period.

- 9.20 However, three months later, on 17th September, 1990, Grace was again brought to see Dr. F with a very severe gum infection. Dr. F recorded “[g]ingivitis [inflammation of the gums] +++ *Decay ++*” and he prescribed “*Flagyl* [antibiotic] [suspension] and *Mycostatin* [antibiotic] oral [suspension]”.
- 9.21 Grace had also been taken to see the general practitioner two weeks earlier on 5th September, 1990 because she had a “[p]urulent Nasal discharge”, for which an antibiotic was prescribed. There was no mention of inflammation of her gums in the notes of that earlier visit.
- 9.22 Dr. F did not have notes of Grace's being brought to him with respect to her teeth or gums between September, 1990 and November, 1996. In her evidence, Mrs. X could not recall whether there were any visits over this period. According to Dr. F's notes, there was one visit in 1993 and one in 1994, but neither related to Grace's teeth or gums.
- 9.23 The condition of Grace's teeth was commented upon by Dr. Walsh in her reports following full medical examinations of Grace in August, 1992 and January, 1995 and she arranged for Grace to be seen in the SEHB dental clinic in January, 1995. These matters are considered below.
- 9.24 The next visit to Dr. F relating to Grace's gums was not until 15th November, 1996, when Grace was brought to him, again suffering with gingivitis. Dr. F noted “[g]ingivitis ++ and change in personality +++ over the past 3 weeks, crying / laughing uncontrollably, [prescribed] *Seprin* [antibiotic] 7.5 mls.” In his evidence, Dr. F said that the observation of change in personality must have come from what he had been told by Mr. or Mrs. X, who brought Grace in to see him. Dr. F could not offer any further evidence on this aspect beyond what was in this note.
- 9.25 Mrs. X had no recollection of this visit or of any related events. However, a note corresponding with this entry was made in Day Service Provider A on 15th November, 1996. This stated “[p]hone call from [Mrs. X] re [Grace]. Brought to doctor in relation to previous call from [staff]. [Grace] has gingivitis, very bad bleeding from gums and mouth sore.”

- 9.26 The next visit to Dr. F with respect to Grace's gums was over two years later. On 15th January, 1999, a locum doctor at Dr. F's practice saw Grace and noted "*pyorrhea*", also known as periodontitis or gum disease. Dr. F said that Grace had a gum infection again for which the locum doctor prescribed "*Flagyl s 5 mls tds 3/7, Calvopen 250 susp 05 qds 5/7*". When asked to comment on the note in his evidence, Dr. F said that he would not describe it as a severe infection, but as an "*obvious infection*" and as a "*significant*" one, since two antibiotics were prescribed. Dr. F's evidence was that Grace was prone to these infections because of her teeth.
- 9.27 Later that year, on 18th October, 1999, Grace had another visit to Dr. F. He recorded: "[p]yorrhea and gingivitis += [foetor or fetor] ++, *behaviour disturbance with it. [Prescribed] Flagyl and Septrin.*" Dr. F said that this meant that Grace had very inflamed gums and pus coming out of them between her teeth. There was a marked smell off her breath (foetor). Dr. F again described it as a significant infection. He noted that he had difficulty examining Grace on this occasion and that she became disturbed when he was examining her.
- 9.28 Mrs. X had no memory of these visits to Dr. F's clinic in January, 1999 or October, 1999 in the course of her evidence.
- 9.29 Grace attended Dr. F's clinic on two later occasions, once in 2003 and again in 2004. Both visits were for the purpose of getting the flu vaccine. There was no record provided to the Commission of any further visits during that time. In October, 2008, Grace was seen by Dr. G for a full check-up. This visit is considered further in the next Section.

Dr. F's opinion on gum infections

- 9.30 Dr. F's evidence was that he saw the gum infections as an unfortunate consequence of the condition of Grace's teeth and the difficulty in attending to them. He said that he did not have a particular concern about these infections at the time and that:

"The problem with the gingivitis, as you know from the subsequent dental records she had to have seven or eight extractions later on under general anaesthetic, the dentist couldn't go near her, so I mean if you have bad teeth you are going to have bad gums, it is a sine qua non."

- 9.31 On the question as whether the level of gingivitis suffered by Grace would be an indicator of no care or an indication of the level of dental care that Grace received, Dr. F noted that, according to his records, she had four or five episodes of gingivitis over the space of about nine years. In this regard, he told the Commission that “[t]here would be plenty of people getting gingivitis and unfortunately in people with mental disability it is a relatively common thing.” He said that this was not, of itself, an indicator of poor care. Dr. F observed that, certainly if you do not brush your teeth you will get caries and gingivitis, but that “*it wouldn’t indicate anything else*”.

Dr. Walsh’s examinations – Grace’s oral health

- 9.32 The involvement of Dr. Walsh with Grace has been extensively reported in the Commission’s First Substantive Interim Report. Dr. Walsh carried out full medical examinations of Grace in August, 1992 and in January, 1995. Both of these examinations were carried out preparatory to her proposed placement into residential care during the time that she was a foster child.⁴⁶
- 9.33 In Dr. Walsh’s report of 13th August, 1992, she recorded that Grace had poor oral hygiene and that her gums were inflamed. Dr. Walsh told the Commission that Mrs. X was advised during the visit in August, 1992 on brushing techniques. During her evidence, Dr. Walsh noted the difficulty with “*cooperation in some people*” (in this case, Grace) in having their teeth brushed.
- 9.34 As noted above, the SEHB was aware of this difficulty in caring for Grace’s teeth from before her placement with Family X. Mrs. X had no evidence to offer concerning this visit to Dr. Walsh in August, 1992. Her evidence extended only to a vague memory of someone, or two people, one a doctor, coming to the house to perform a medical examination of Grace in 1992.
- 9.35 In Dr. Walsh’s next report on Grace, almost two and a half years later, on 24th January, 1995, she made a note that Grace’s teeth bled if brushed. Dr. Walsh was given this information from Mrs. X, who brought Grace to the clinic on that occasion. Dr. Walsh said that Mrs. X had been advised at the 1992 visit on brushing techniques and going to the dentist. Dr. Walsh told the Commission that Mrs. X told her that she did not go to a dentist “*because of other family issues*”, and Dr. Walsh noted this at

the time. Dr. Walsh was unable to expand on her note of this by the time she gave her evidence to the Commission.

9.36 There was a dental clinic in operation in the medical centre on the day of the visit on 24th January, 1995 and Dr. Walsh asked the dentist to see Grace. Dr. Walsh said that she *“could see [Grace’s] teeth were causing problems, her gums particularly, and there happened to be a dental clinic in [a health centre] on that particular afternoon, and again it was by appointment, but I asked [the dentist] if he would see the child because she had come in, just to facilitate the family, and he did see her.”*

9.37 The outcome of that visit was recorded in Dr. Walsh’s note. This was to the effect that there was no acute dental treatment, such as fillings or extractions, required for Grace. Dr. Walsh also made a note that, if Grace needed orthodontic treatment, it would need to be done at the Dental Hospital in Cork. In this regard, it should be noted that Grace had very prominent and protruding front teeth. However, there was no such appointment made for Grace by the clinic. Dr. Walsh also noted that Mrs. X was again advised on correct brushing techniques.

Awareness of SEHB/HSE officials about Grace’s dental care

Grace as a foster child - concern about teeth or gums

9.38 The role of the SEHB in the monitoring and care of Grace as a foster child over the period from February, 1989 to the end of 1996 (when Grace turned 18) has been reported in the First Substantive Interim Report. Over this entire period that Grace was in foster care within the authority of the SEHB, there was no reference of any kind in the documents and records disclosed to the Commission of any concern about the condition of her teeth or gums, apart from what was set out in Dr. Walsh’s reports above. Furthermore, apart from Dr. Walsh’s reports, there was no evidence to the Commission from any other employees or officers of the SEHB who were involved in Grace’s case, raising a concern about the condition of her teeth or gums or her oral hygiene over the above period, either internally in the health board or with Mrs. X or Mr. X.

⁴⁶ See paragraphs 10.70 to 10.78 in Chapter 5 and paragraphs 2.25 to 2.32 in Chapter 6 of the First Substantive Interim Report.

- 9.39 Throughout the time that Grace was in foster care as a child in the SEHB area, and apart from the visit to the dental clinic in January, 1995 organised by Dr. Walsh on that day, the Commission had no evidence in the course of its investigations of any arrangements having been made by the SEHB for Grace to be seen by a dentist.
- 9.40 It was also the case that the Commission had no evidence of any enquiry being made or follow-up of any kind by or on behalf of the SEHB as to whether Grace had ever been taken to a dentist by Mrs. X or Mr. X during her years as a child in foster care.

Grace as a vulnerable adult - concern about teeth or gums

- 9.41 The attention, such as it was, paid to the issue of Grace's oral hygiene within the SEHB/HSE between the end of 1996 and the re-engagement by the HSE with Grace's case from 2007, was evidenced in the accounts given at the Commission of SEHB/HSE personnel involved in Grace's case, as set out below. As already reported, contact with Grace over this period was minimal and Grace was not seen by a social worker or any other official from the SEHB/HSE for a period of six years between June, 2001 and September, 2007.

Ms O'Brien

- 9.42 The involvement of Ms O'Brien, Social Worker for Adults with Intellectual Disabilities and SEHB key worker to Grace from late 1996 to 1997, in Grace's case has been reported above and in the First and Second Substantive Interim Reports. On the matter of Grace's teeth, Ms O'Brien said that dental concerns never came to her attention. Her evidence was that nobody brought to her notice any difficulties that they had with respect to Grace's teeth and that she herself did not notice any dental problems with Grace.

Ms Jones

- 9.43 Ms Jones' involvement in Grace's case is also reported above and in the Second Substantive Interim Report. She was the social worker with responsibility for Grace's case from September, 1997 until early 1999. Her engagement was minimal and there were only two recorded visits to Grace's placement with Family X, in January and

March, 1999, in the context of the case being handed over to her successor, Ms Leyshon.

- 9.44 On 20th January, 1999, Ms Jones called to Mr. and Mrs. X's house. In the course of their conversation, Mr. X told her that Grace had "*pi* [pyorrhea] *gum disease*", a gum infection which had only recently been discovered. Ms Jones recalled being told by Mr. X that Grace had been taken to the dentist some months previously but that, as *per* her note from the time, the gum disease had only been discovered "*a few days ago, when they brought [Grace] to their doctor... for a sore throat*". Ms Jones said that she knew that Grace had sore throats but that it was only at this visit that she realised that they were related to her gums. This conversation coincided with Grace's having been taken to see Dr. F on 15th January, 1999 because of gum disease, as reported above. The Commission could not establish whether Grace had been also taken to a dentist a few months earlier.
- 9.45 Ms Jones was aware of a concern in relation to Grace's oral hygiene and felt that gum disease might have been addressed through better oral hygiene. She said that she would have raised issues such as this with the Public Health Nurse, Ms Hawe, at the time. Ms Jones said that, while it would have been within the remit of her role to make appropriate checks to ensure that Grace had been brought to a doctor or dentist, she did not disbelieve Mrs. X's assertion that Grace had been brought to the dentist. While Ms Hawe did not recall any such discussion with Ms Jones, she did recall that Grace's teeth were not in good condition at the time.
- 9.46 The Commission found that there was no further follow-up by any official of the SEHB with respect to the condition of Grace's teeth or gums at this time.

Ms Leyshon

- 9.47 Ms Leyshon's extensive involvement in Grace's case from January, 1999 to June, 2001 is referred to above and has been reported in the Commission's Second Substantive Interim Report.
- 9.48 With respect to her knowledge of any issue for Grace concerning her teeth or gums, Ms Leyshon made a note of a conversation with Mr. M, the manager of Day Service Provider A, on 3rd February, 2000. This included a reference to Mr. M's advising her that Grace had sore gums and was being fed soft foods. Ms Leyshon also recorded

that Mrs. X had told Day Service Provider A that Grace's dentist had told them that he would have to remove all of Grace's teeth.

- 9.49 This corresponded with a note made by CW2 in Day Service Provider A a week later, 11th January, 2000, recording that *"Mrs. [X] rang to say that [Grace] has had the flu. She got a cold first, then the flu. Her gums are also sore and swollen and [Grace] is finding it hard to eat anything. She is on antibiotics and will be in on Monday. Mrs. X also [said] that [Grace] fainted during her period. Her teeth will have to be removed eventually."* Ms Leyshon said that she was surprised by this information, as she had not been told of any issue regarding Grace's teeth by Mr. or Mrs. X. Ms Leyshon had not noticed anything about Grace's dental condition on her two visits to Family X. CW2's note is referred to further below.
- 9.50 The fact that Grace had suffered gum infections and sore throats was raised at a meeting concerning her which was held in the SEHB a year later, on 22nd February, 2001. This meeting was attended by a core group of professionals in the SEHB who were involved or previously involved in her case and by Mr. M. The minutes of the meeting recorded that *"[Grace] was frequently absent for long periods in the early days. She was kept at home for sore throats, colds and gum infections for weeks at a time."*
- 9.51 The Commission is satisfied that the above was the last reference made to Grace's teeth or gums until the revival of the HSE's involvement in Grace's case from 2007 onwards, as reported in Volume 1 of the Commission's Final Substantive Report. There was no evidence to the Commission, either by way of documentary records or from witnesses, of any discussion, much less any action, taken within the SEHB/HSE with regard to dental care for Grace at any stage over that period. This was not in the least surprising, having regard to the complete failure of the SEHB/HSE to follow up on or engage with Grace's care needs or to monitor how she was being cared for over that period, as reported in the Second Substantive Interim Report.
- 9.52 As reported in Chapter 8 of Volume 1, the first engagement by the HSE with respect to Grace's teeth following the resurfacing of her case in 2007 was when Ms Browne wrote to Mrs. X on 10th September, 2008 to say that dental assessments would be taking place and to ask if she could take Grace to them. Mrs. X replied on 16th September, 2008, saying that she would take Grace to the dentist and to anything else that Grace had to have done. On the 17th September, 2008, Ms Browne emailed

the Senior Dental Surgeon, Dr. Haran, stating *inter alia* that, as far as was known, Grace had not had a dental check-up for some years and asking if it would be possible to see Grace.

- 9.53 It appears that this plan to have Grace seen by a dentist was first raised at a Vulnerable Adults Committee meeting in August, 2008, where Ms Browne had been tasked with asking Mrs. X to take Grace to the dentist. Why dental issues came to the fore is noted below.

Awareness of condition of Grace's teeth at Day Service Provider A

- 9.54 Difficulties with the care of Grace's teeth and gums were apparent to the management and care staff in her day placement. Mr. M described Grace's teeth as "*very prominent*" and "*very noticeable*". Grace's front teeth protruded and she had high gums. He said that the staff had a toothbrush for Grace and washed her teeth. Mr. M said that he never brushed Grace's teeth, as he only brushed the teeth of male service users. He was conscious that the staff had difficulty cleaning Grace's teeth. Reflecting on this at the Commission, Mr. M did not know whether this was because of difficulties in opening Grace's mouth or her biting on the toothbrush.
- 9.55 CW2 recalled in her evidence that sometimes Grace's gums would bleed. She said that they did not bleed on a daily basis, but that it could happen several times a week. CW2 said that "*they weren't in good shape*" and that sometimes her teeth were dirty, leading the care assistants to clean or attempt to clean them if she would let them. It was a bit of a chore to try to clean Grace's teeth, she said, but they tried to be gentle about it and tried not to hurt her when doing that.
- 9.56 In her evidence, CW1 said that Grace's teeth and gums got progressively worse over the time she encountered her. She recalled Grace as having very swollen and very red gums. CW1 said that, at times, one could see more gums than teeth, "*really swollen*" and "*sore looking*". She said, however, that she herself was not involved in the brushing of Grace's teeth in Day Service Provider A.
- 9.57 CW7, who started working in the day service in February 2008, recalled that she noticed a smell from Grace's breath and that Grace's teeth "*weren't very well kept at all*". CW7 recollected that Grace did not tolerate teeth brushing very well, although she also said that she did not remember what Grace's reaction was to having her

teeth brushed. She made one note about Grace's teeth in February, 2009, namely that her *"teeth [were] brushed on arrival into the [day centre] by myself, [CW7]. Gums bled quite badly"*. CW7 did not recall regularly brushing Grace's teeth. She said that she did not *"recall having to do that very often"*.

- 9.58 Ms D, who first met Grace in March / April, 2008, described Grace's oral hygiene as *"really, really poor"*, saying that her teeth *"weren't clean"*. Ms D did not raise these issues with Mrs. X in 2008. She indicated to the Commission that Grace's attending day service was the priority then. Ms B noticed similar issues regarding Grace's oral hygiene at this time.

Evidence on question of whether Grace had dental treatment

- 9.59 CW2 did not recall her conversation with Mrs. X on 11th January, 2000, referred to at paragraph 9.49 above. When she was asked about the note during her evidence, Mrs. X recalled telling Day Service Provider A that Grace's teeth would have to be removed eventually. She said that the reason for this was because Grace was *"breaking them all with the keys"*. She said that she knew that they would have to be removed and that this was because they were *"rotten"* and *"bleeding"*. Mrs. X said that she had learnt that they would have to be removed from a dentist at St. Otteran's hospital in Waterford City and that she remembered going there with Grace on three occasions. She thought that the dentist was female, but could not remember her name.
- 9.60 About a month later, on 16th February, 2000, CW1 made a note that *"Mr. [X] rang to say that [Grace] wouldn't be into Tues 22nd Feb – getting dental work carried out."* CW1 could not remember anything specific about Grace's being absent to have dental work carried out. At the Commission, it became apparent that Mrs. X's account of Grace's having been seen by a dentist in St. Otteran's in or around the year 2000 appeared to derive instead from the occasions when she brought Grace to Dr. Haran much later in 2008/2009, as reported below.
- 9.61 In his evidence, Mr. M also recalled Grace's having dental work carried out at some stage when she was living with Mrs. X. He did not recall when that was, or the nature of the work carried out. Mr. M also observed that *"I couldn't say that she came back in again and I noticed a huge difference. You know there could have been remedial work at the back of her mouth and whatever else"*.

- 9.62 Mrs. X's evidence to the Commission about having taken Grace to a dentist became very confused and unclear. A document dated 3rd April, 2001 and entitled "*Information Form*", which was prepared in Day Service Provider A, recorded the name and address of a dentist for Grace. The Commission is satisfied that this document would have been prepared using information partly drawn from Mrs. X. However, Mrs. X could not remember its being completed. She told the Commission that she did not ever remember taking Grace to the dentist named in the information form and that it was to St. Otteran's Hospital that Grace had been taken. Mrs. X said that she knew of the dentist named in the form, but she told the Commission that, as far as she was aware, neither she nor anyone else in Family X had ever attended him. There were no records in that dental practice of Grace's ever having attended it and the Commission is satisfied that she did not do so.⁴⁷ The Commission is satisfied that this information on Grace's dentist, given to Mr. M for the purpose of completing the information form, was wrong.
- 9.63 The Commission also heard evidence from Ms B that Mrs. X was unable to name the family dentist when she was asked about this at a PCP meeting in Day Service Provider A in July, 2009.⁴⁸
- 9.64 In her evidence about Grace's being taken to a dentist in St. Otteran's Hospital, Mrs. X initially said that there was no treatment given. However, she went on to say that they took out some of Grace's teeth, indicating that this was at the back of Grace's mouth, and that she was told that all of Grace's teeth would need to come out eventually. Mrs. X also referred to being given a "*battery toothbrush*" and different toothpaste by this dentist and said that she found it easier to brush Grace's teeth with the battery toothbrush as Grace was less resistant, although Grace did not like it.
- 9.65 However, Dr. Haran, whose evidence is considered below, confirmed that when she examined Grace in 2008, she had not had any extractions (something which, in all likelihood, would have required a general anaesthetic) prior to her examination.
- 9.66 Further, on the basis of Dr. Haran's examination in 2008 (detailed below), it appears that it was Dr. Haran who advised Mrs. X on the use of a battery toothbrush and who instructed Mrs. X on its use at Grace's appointments with her from 2008 onwards.

⁴⁷ An Garda Síochána took a statement on 26th March, 2011 from a dental surgeon working from the surgery referred to in the

9.67 With respect to Mrs. X's evidence that Grace had teeth extracted in or around the year 2000, there was no evidence of any further follow-up with respect to Grace's teeth subsequent to 2000/2001 or any other occasions of dental visits up until 2008, when Grace was taken to a dentist.

9.68 The Commission does not accept that Mrs. X's evidence of Grace's having teeth removed in or by the year 2000 is correct. The Commission's findings on the evidence with respect to whether Grace was seen by a dentist over the years she resided with Family X and Mrs. X's evidence on this matter are addressed further below.

Dr. Maura Haran

Preliminary

9.69 Dr. Haran is a Senior Dental Surgeon in Special Needs in the HSE in Waterford and has been in that role since 2002. She obtained her degree in 1987 from University College Cork and subsequently, in 1997, she studied for a Masters in Dental Public Health. She also obtained a Diploma in Special Care Dentistry in Trinity College, Dublin in 2013.

9.70 The best evidence to the Commission on the overall condition of Grace's teeth and gums came from Dr. Haran. As a senior dental surgeon, specialising in patients with special needs, Dr. Haran also gave valuable evidence to the Commission about the challenges that can arise in maintaining oral hygiene in a case such as Grace's.

9.71 Dr. Haran first saw Grace on 8th October, 2008, on referral from Ms Browne, at that time the Coordinator of Disability Services in Waterford Community Care. Ms Browne's involvement in the management of Grace's case is extensively reported in Volume 1 The Commission is satisfied on the evidence received that this was the first time that Grace was ever referred to a dentist through the SEHB or the HSE since she came into the care of the SEHB in 1987, save for her impromptu visit to the dental clinic in January, 1995 (reported above). Grace attended Dr. Haran five times between October, 2008 and November, 2009.

Information Form. His practice was previously operated by the dentist named in the Information Form. That dental surgeon confirmed that he had searched his records together with those of the previous practice and that no records existed for Grace.

⁴⁸ The PCP meeting took place on 3rd July, 2009 and is reported upon in Chapter 17 of Volume 1.

- 9.72 In her evidence to the Commission, Dr. Haran said that she and Ms Browne had a discussion shortly after she received an email from Ms Browne in September, 2008,⁴⁹ during which Ms Browne told her that there was a possible case of neglect being investigated and that there was a possibility that Grace was going to be made a ward of court.

Dr. Haran's reports

- 9.73 Dr. Haran prepared two dental reports concerning Grace in the course of her involvement in her case.
- 9.74 In a report that she prepared following the extraction of seven molar teeth in August, 2009, Dr. Haran reported that:

"... [Grace's] oral health was extremely poor at that stage due to very poor oral hygiene, resulting in gross build-up of calculus (tartar) and plaque. While she appeared to be decay free, her gums were in a very poor condition due to inadequate brushing over a prolonged period of time."

- 9.75 Dr. Haran went on to observe:

"However, it was immediately apparent that providing effective oral hygiene for [Grace] is particularly challenging as she only tolerated any oral intervention very briefly."

- 9.76 Dr. Haran detailed the difficulty in providing good oral hygiene and observed that Grace intermittently would not allow staff within the day service to brush her teeth.

8th October, 2008 – first visit

- 9.77 On Grace's first visit, Dr. Haran recalled that Grace was reluctant to tolerate any intervention but that she was, nonetheless, cooperative. Dr. Haran was able to

⁴⁹ Reported upon in Volume 1.

examine Grace to a degree, although she noted that Grace was inclined to pull away regularly. Dr. Haran said that Grace had a strong gagging tendency, her opinion being that this could have been an oral facial dysfunction. She told the Commission that this could be a feature of people with severe profound disabilities.

- 9.78 On the subject of brushing, Dr. Haran explained that patients with severe profound disabilities were very oral sensitive and did not tolerate brushing or oral intervention well. Dr. Haran said that she certainly considered Grace to have “*severe profound disability*”. She was not surprised to find that Grace was not comfortable with oral intervention.
- 9.79 The first appointment went relatively well, considering that Grace was unfamiliar with the environment, which Dr. Haran observed would have been intimidating for somebody with a severe disability. Dr. Haran used a sedative gas, namely nitrous oxide, and this allowed her to examine Grace reasonably well. She recalled that Grace’s mouth was in “*a very poor state*” and that she had gross tartar all over her mouth and very inflamed gums. Dr. Haran observed that “[t]he *teeth probably weren’t being brushed at all at that point would be my guess, they were in a bad way.*”
- 9.80 Dr. Haran noted that Grace had gingivitis (gum inflammation) and periodontitis (gum disease). The teeth themselves, however, appeared to be decay free.

Teeth brushing

- 9.81 Dr. Haran said that the cause of the gingivitis and periodontitis was “*poor brushing basically*”. She explained that there are normal oral bacteria in the mouth, but that if plaque levels are not kept at a low level, the bacteria will release toxins that invade the gums, causing them to become inflamed, as the tartar and plaque build up. She said that this results in the gums being stripped back from the teeth, with the teeth then becoming loose because the supporting structures are no longer where they should be.
- 9.82 Dr. Haran said that not everybody is prone to gum disease and that, even with poor oral hygiene, gum disease might not develop. She emphasised, however, that where patients are prone to gum disease and oral hygiene is poor, gum disease will develop. Dr. Haran also described the progression of gum disease as a very individual thing. Grace was 30 years of age when Dr. Haran first examined her. Dr.

Haran observed that this was quite a young age to have such advanced gum disease, but she observed that Grace certainly had a predisposition to gum disease. She said that everybody has an individual resistance or susceptibility to oral disease; some people were more likely to develop gum disease because of their immune responses, whereas others with the same habits might not develop gum disease.

9.83 With her experience as a dental surgeon for persons with special needs, Dr. Haran explained that she had seen other patients who did not engage with services and who, at their first appointment, might have had very poor oral hygiene but would not have developed gum disease to the same extent as Grace. She said: “... *I would guess that the teeth basically weren’t being brushed and probably hadn’t been brushed probably forever you know but I don’t know that.*” A total absence of brushing would, she explained, exacerbate the situation considerably. Dr. Haran told the Commission that “[i]f you’re susceptible, you are obviously always at risk but [if] the control of gum disease is very good, thorough long term all the time...it can be controlled and maintained to some degree”.

9.84 Dr. Haran said that she had managed to control Grace’s gum disease since Grace had treatment under general anaesthetic in August, 2009. Dr. Haran explained that the aim was to try to counteract Grace’s susceptibility to gum disease and to prevent deterioration through excellent oral hygiene.

9.85 Dr. Haran asked Mrs. X to bring an electric toothbrush to the next appointment.

22nd October, 2008 – second visit

9.86 On 22nd October, 2008, Grace attended with Dr. Haran again and had her first session of scaling, which was carried out with sedation in the form of 5 mgs of *Valium*. Mrs. X was present at the appointment. Dr. Haran advised Mrs. X that she (Dr. Haran) might ultimately need to administer a general anaesthetic to Grace in order to conduct scaling. Dr. Haran told the Commission that the use of a general anaesthetic was considered the last option; if patients could tolerate treatment relatively comfortably without the use of a general anaesthetic, that was how it would proceed. During this appointment, Dr. Haran said that she was seeing how Grace was progressing.

- 9.87 Mrs. X brought the battery-operated toothbrush to the second appointment as she had been requested to do, and Dr. Haran demonstrated to her how to go about brushing Grace's teeth in the most tolerable way. Dr. Haran said that this could be done in little short spurts, taking rests and trying to brush areas quickly, particularly where gagging might be caused. She said that there were a lot of specific things that could be done in order to help a patient to tolerate brushing. She agreed that there was some engagement by Mrs. X in this process, remembering her as being an *"elderly woman"*. Dr. Haran said that she found Mrs. X to be a quiet woman, adding that, whatever she (Dr. Haran) said, Mrs. X went with it, rather than having any major discussion about it.

5th November, 2008 – third visit

- 9.88 Dr. Haran said that on Grace's third visit, she noted that Mrs. X was brushing Grace's gums thoroughly and Mrs. X told her that the bleeding had stopped. She and Mrs. X talked about brushing on each visit. Dr. Haran said that Grace's gums were red and puffy, which was a result of gross inflammation from years of plaque and tartar build-up, and that the inflammation would not clear quickly. According to Dr. Haran's transcribed notes, *"thorough scaling of buccal surfaces"* was undertaken that day, meaning that the outside surfaces of Grace's upper teeth were scaled. On each visit, it was necessary to give sedation before scaling.

25th November, 2008 – fourth visit

- 9.89 On 25th November, 2008, Dr. Haran carried out further scaling of the buccal surfaces of Grace's teeth. Although Dr. Haran began treatment on the inside surface, she noted that Grace only tolerated treatment on the outside of the teeth and that it would have been too much to treat the inside as there was a lot of tartar. Dr. Haran discussed post-treatment care with Mrs. X.
- 9.90 Dr. Haran saw Grace for scaling three times after the initial appointment because, she said, in her experience, patients with a profound disability were not at their most relaxed and comfortable on their initial visit. She noted that such patients would find the environment threatening and the oral intervention difficult. Dr. Haran noted that *"[Grace] only tolerated any oral intervention very briefly"* and that *"cooperation is always intermittent."*

- 9.91 There was no further visit for scaling until Grace's visit in August, 2009, reported below.

26th August, 2009 – fifth visit

- 9.92 On 26th August, 2009, after Grace went into residential care, she underwent significant dental treatment with Dr. Haran which involved the extraction of seven molar teeth that were mobile, a scaling, and root planing. These procedures were carried out under general anaesthetic. Although the teeth that were removed were decay-free, they were mobile as a result of Grace's advanced gum disease.

Providing oral care – questions of neglect

- 9.93 From her experience in the area of providing dental care for persons with special needs, Dr. Haran provided important context for her observation of the neglect of Grace's teeth, as follows:

"So I would say straightaway, that isn't necessarily that unusual, in that people who haven't engaged with services and who have sensitivity to brushing and maybe would be pushing people away and refusing brushing, that even very good caring parents may not pursue brushing if it's difficult and the person doesn't want and doesn't tolerate it...because they haven't been maybe educated in how to train somebody into tolerating brushing..."

- 9.94 Dr. Haran told the Commission that she came across people with severe intellectual disabilities whose teeth were neglected because of the fundamental difficulty experienced by families in getting the persons in question to brush their teeth, or in assisting them in brushing. In this regard, Dr. Haran's view was that Grace's dental presentation was not necessarily indicative of anything further. She went on to say:

"I mean obviously the teeth were being completely neglected but as I said you will see that, not frequently obviously with someone who is engaged in services all the time, we do teach people how to get in there and get brushing and how to help the person who is doing brush work to tolerate it".

9.95 Dr. Haran also told the Commission that:

“Everything else, you know, all of her other presentation was good. So, neglect of the mouth in the absence of, you know, any other neglect wouldn’t ring alarm bells with me for somebody who has got a profound disability and, also, who also had sensory issues because she was gagging when I was trying to examine her...So that wouldn’t necessarily, you know obviously you would be trying to improve matters but as an initial presentation I wouldn’t be concerned that this was a sign of general neglect”.

9.96 From her own experience as a special needs dental surgeon, Dr. Haran explained:

“I wouldn’t be judgemental of people when they come in about brushing because I realise the difficulties so I always really concentrate on showing them how I would do it and what they can do rather than kind of [asking them] ‘what are you doing and why are you doing [it] so badly?’ It can be difficult.”

9.97 Dr. Haran’s report recorded that Mrs. X “[d]id try her best to work on the brushing in spite of the difficulties involved” and Dr. Haran told the Commission that she and Mrs. X talked about the brushing at every visit. In this regard, it was clear at the Commission that Dr. Haran understood the requirement for repeat instructions on how to brush correctly, rather than advising on this on a once-off basis.

9.98 The evidence to the Commission about what was required for Grace’s daily dental care certainly underlined that this aspect of her care required some know-how as well as skill, persistence, time and patience.

Lack of special care dental service

9.99 Dr. Haran pointed out that there was no structured special care dental service in place in the entire country prior to 2002. Instead, there were pockets of special care services operating in certain areas, including Waterford.

Care of Grace's teeth advised – post-extraction

9.100 After the above extractions were carried out, Dr. Haran advised that she should see Grace every four to six weeks. She saw her regularly for maintenance scaling from 2009 onwards. In the report that Dr. Haran completed after Grace's move to the residential placement, she observed as follows:

"The problem with maintaining good oral hygiene is ongoing and care staff tell me that some days [Grace] won't allow brushing at all. In spite of the best efforts of carers and dental staff, the condition of the gums continues to deteriorate a bit."

9.101 Dr. Haran observed at that stage that Grace's lower anterior teeth were slightly mobile, and the upper anterior teeth quite healthy, as they were the *"most easily accessible for brushing"*. She felt that Grace had a reasonable level of oral health at that time. She advised, however, that all of Grace's other teeth were:

"...still at high risk of progression of gum disease due to the extreme difficulty of providing effective oral hygiene."

9.102 In her second report, dated 23rd March, 2016, Dr. Haran noted that inhalation and oral sedation had proved relatively ineffective when attending to Grace's oral care and that, from September, 2013, her dental care was provided under intravenous sedation. In this report, Dr. Haran anticipated that a general anaesthetic might be required at some future date, depending on Grace's level of cooperation while undergoing dental treatment.

9.103 At this stage, Dr. Haran considered Grace's oral health to be reasonably good with the gum disease quite well controlled, although progressing slowly. She noted that Grace's current carers were *"working very hard to maintain good oral hygiene which is essential to slow this progression"*.

9.104 Grace's toleration of oral hygiene had improved considerably over time, resulting in significant improvement in her oral health. Dr. Haran continued to highlight the difficulties associated with providing her with necessary dental care. Her opinion in March, 2016, as recorded in her report, was that it was essential that Grace continue to access specialist dental care.

Findings with respect to Grace's dental health

Attendances at dentist

- 9.105 The Commission is not satisfied, on the evidence received by it, that Grace was brought to be seen by a dentist over the years she resided with Family X, save as referred to below.
- 9.106 The evidence established that Grace was seen in the dental clinic when she was taken for a full medical examination by Dr. Walsh in January, 1995, as reported above. The outcome of the dental examination reported that no fillings, extractions or acute treatment were required. There was no referral for orthodontic treatment and it was simply noted that, if such treatment was required, it would have to be done in the Dental Hospital in Cork.
- 9.107 There was some evidence that Grace may have been taken to an unidentified dentist shortly before January, 1999, as reported at paragraph 9.44 above. This coincided in time with a documented visit when Grace was taken to see her general practitioner (Dr. F), because of problems with her gums. The fact that Grace was taken to the general practitioner on a number of occasions for treatment of her gum disease, as reported above, did establish that there was some care and attention paid to her gum problems by Mrs. X, with medical attention sought to ameliorate those problems from time to time.
- 9.108 However, the Commission rejects the evidence of Mrs. X that Grace had been treated by a dentist in St. Otteran's Hospital in or about 1999 and 2000 and that she had a number of her back teeth removed at that stage. This evidence was contradicted by the evidence that Grace had had no prior extractions when she was first seen by Dr. Haran in 2008.
- 9.109 Although Day Service Provider A had a note for February, 2001 of being told by Mr. X that Grace would be out as she was undergoing dental work, the Commission did not have any evidence of any particular dental work for Grace at that time. There was no evidence of any particular treatment having been administered to Grace at this time and the Commission cannot establish that this was the case. The Commission found that Mr. M was furnished with incorrect information by Mrs. X when he

recorded in the aforementioned information form that Grace had a particular named family dentist in 2001, when the Commission is satisfied that this was not the case.

- 9.110 The Commission found Mrs. X's evidence to be fundamentally unreliable on the question of Grace's attendance for dental treatment over the years that she resided with Family X. The Commission could not accept her evidence as credible on this issue.

Dental health – day-to-day care

- 9.111 The condition of Grace's teeth and gums, as described by Dr. Haran, evidenced ongoing neglect of Grace's oral care. The Commission is satisfied that this significantly contributed to the development of gum disease, to which Grace was already predisposed.
- 9.112 Having regard to the evidence on this issue, the extensive difficulties involved in brushing Grace's teeth and maintaining oral hygiene is not a factor to be disregarded. The Commission accepts the evidence of Mrs. X that brushing Grace's teeth was a very difficult task, that often she was not successful in doing so, and that Grace hated to have her teeth brushed. The Commission is satisfied that Mrs. X did make some efforts to brush Grace's teeth. However, given the deteriorating condition of her gums in particular, it is likely that Mrs. X had abandoned the effort of brushing over time, or that any ongoing efforts were sporadic and entirely ineffective.
- 9.113 The evidence to the Commission about the difficulty in brushing Grace's teeth was supported by the evidence from personnel at Day Service Provider A. The difficulties that Dr. Haran encountered in her practice in this area, as well as Grace's tendency to gag, were also set out at the Commission in clear and realistic terms by Dr. Haran.
- 9.114 As reported above, difficulties with brushing Grace's teeth continued after she was removed from Mrs. X's care in July, 2009.
- 9.115 Although Mrs. X received some advice on brushing Grace's teeth from Dr. Walsh in 1992 and in January, 1995, it was not until Grace was referred by the HSE to Dr. Haran that Mrs. X was given instruction over a series of visits on techniques to assist in doing this effectively. This was reinforced by Dr. Haran on each visit, which resulted in an improvement in the condition of Grace's gums. It was entirely obvious

from the evidence heard by the Commission that sustained instruction, support and oversight needed to have been given to Mrs. X at a much earlier stage, if Grace was to have the type of oral care needed to keep gum disease at bay. This did not occur. By the time of Dr. Haran's involvement, the HSE was about to remove Grace from Mrs. X's care. This came too little, too late.

- 9.116 It is of note that, in highlighting the difficulties associated with providing Grace with the necessary dental care on an ongoing basis into the future, Dr. Haran's opinion in 2016 was that it was essential that she continue to access specialist dental care.
- 9.117 Notwithstanding the difficulties that could arise in managing Grace's oral care, however, the Commission found that the standard of her oral hygiene was such as to establish neglect on the part of Mrs. X with respect to her dental care and neglect in failing to bring her to a dentist over the years. In that regard, the Commission has not accepted Mrs. X's evidence of Grace's having had dental treatment. Mrs. X's evidence to the effect that she thought that Grace was breaking her teeth by tapping them with her toy keys and that Grace's teeth were "*rotten*" only underlined the extent to which the requirement for Grace to have dental care was fundamentally neglected.
- 9.118 The Commission is satisfied that by the year 2008, Grace's oral hygiene had been substantially neglected for some years to the extent that seven of her teeth needed to be extracted in August, 2009 as a result of gum disease.
- 9.119 The Commission is satisfied on the totality of the evidence that, in all likelihood, the condition of Grace's gums and teeth was accepted as the norm for Grace over the years and that that attitude of acceptance resulted in a fundamentally neglectful approach by Mrs. X and Mr. X to issues to do with Grace's dental care. The poor state of Grace's dental hygiene was obvious to Mrs. X and the Commission considers that more steps should have been taken by her over the years to seek regular dental check ups and any necessary dental treatment.
- 9.120 In making the above findings, the Commission is mindful of the evidence of Dr. Haran that even very good caring parents may not pursue brushing if it is difficult and the person does not want it, and that neglect of the mouth, in the absence of any other neglect, for somebody who had a profound disability and sensory issues, such as Grace, would not ring "*alarm bells*" for her. The Commission accepts the evidence that dental hygiene for people with profound intellectual difficulties can be very

challenging. However, the Commission is satisfied that the lack of attention to Grace's teeth in the circumstances of her case did amount to serious neglect of this aspect of her care.

The responsibilities of public bodies

9.121 The fact that Grace's teeth and gums deteriorated up to the time that she attended Dr. Haran for the first time in 2008, was clearly contributed to by the absence of any monitoring, oversight or follow-up on concerns about her dental care. The awareness within the SEHB and the HSE of difficulties with her teeth and gums, both as a foster child and thereafter as a vulnerable adult, has been reported above. No real attention was paid to these difficulties and the effect that Grace's poor oral care had upon her overall well-being. Apart from the impromptu visit to the dental clinic arranged by Dr. Walsh in January, 1995, the responsibility of attending to the care of Grace's teeth and gums was simply left to Mrs. X without any oversight or follow-up of any kind thereafter in order to ensure that Grace's dental care was properly attended to, until 2008.

9.122 This was a significant failure of the duty of care that the SEHB and the HSE owed to Grace, both as a profoundly vulnerable child and adult, over the period reported upon in this Chapter. The manner in which her case was managed, the system failures and the lack of any engagement of any kind with her case between mid-2001 and the start of 2007 have been reported in the Second Substantive Interim Report.

9.123 The Commission found, on the evidence, that Grace, as a child with profound disabilities in the care of the State, and as a profoundly vulnerable adult, received only the most minimal attention to this aspect of her care as a child, and none at all as an adult. This was a stark illustration of the extent of these failures of the SEHB and the HSE in Grace's case.

Day Service Provider A

9.124 At the time that the SEHB arranged for Grace to attend Day Service Provider A in 1995, the overall condition of her teeth was known to SEHB personnel. The fact that Grace had ongoing difficulties with her teeth and gums was known to SEHB/HSE personnel over the years that followed. As reported, there was no engagement with her care from mid-June, 2001 until July, 2007.

9.125 Over the course of Grace's attendance at Day Service Provider A, as reported above, care staff sometimes took it upon themselves to make efforts to brush her teeth. The Commission is satisfied on the evidence that the care of her teeth was not, in fact, the responsibility of the day centre, rather the care staff assisted Grace with her personal care where they saw a need to do so. The Commission accepts the evidence that Mr. M thought that Grace had a named dentist and that she had undergone some dental work in or about the year 2000, in the circumstances reported earlier. The question of whether or not Grace should attend a dentist was not a matter for the day centre, who did not have responsibility for that aspect of Grace's care. The long-standing issues with Grace's teeth and gums were, to the knowledge of Day Service Provider A, known to the SEHB/HSE.

Effect on Grace

9.126 The Commission is satisfied that the failure to maintain oral hygiene and regularly and effectively to brush Grace's teeth was a substantial factor in her development of gingivitis or gum disease. Grace was predisposed to this condition and, although it cannot be concluded that she would not have developed this condition over time in any event, the evidence supports a finding that the neglect of the brushing of Grace's teeth was the principal cause of the development of the condition as it manifested in Grace.

9.127 Grace suffered swelling of the gums and infections. When this occurred, undoubtedly, it caused her to suffer considerable pain and discomfort. Grace's gums would regularly bleed and she was reported to tap her teeth and her gums with her plastic keys. Mrs. X's evidence was that this tapping with the keys was the cause of, or contributed to, the state of Grace's teeth. Whether Grace tapped her teeth as a sensory behaviour or whether it was related to pain or discomfort or a combination of both cannot be definitively determined on the evidence. However, it was clear that Grace suffered ongoing problems with her mouth. The manner in which she was affected by problems with her teeth and gums was conveyed in the evidence of Mrs. X and was also observed by staff in her day placement, as well as being conveyed through the medical records and the evidence of Dr. F and Dr. Haran.

9.128 A feature of the condition of Grace's teeth and gums was that it could cause a strong and offensive odour. In the evidence to the Commission, this was noticed by care staff who engaged with Grace in her day placement and was also described in Dr.

F's notes as "*foetor*". Although the odour was not reported to be always noticeable, it was something noted with sufficient regularity to be a negative feature of Grace's presentation. This clearly was an aspect of Grace's presentation, which negatively impacted upon her personal dignity.

9.129 A consequence of Grace's gum problems was that it resulted in her being unable to attend at her day placement at times. Problems with Grace's gums and her sore throats were associated with each other.

9.130 It must also be observed that, having regard to the totality of the evidence, problems with Grace's teeth and gums, while recurring, did not manifest themselves all of the time. There were accounts given about Grace in the course of the extensive evidence to the Commission, where the issue of her teeth did not feature or when she was not observed as manifesting problems with her teeth or gums. Other than when Grace was not able to attend her day placement, it was not an issue that was generally reported as preventing her participation in activities in Day Service Provider A or at home. However, clearly Grace's poor dental health, in particular with respect to her gums, was ever-progressing. The evidence the Commission received about her daily life is more fully reported in Chapter 6 of this Volume.

9.131 The outcome of the development of Grace's gum disease, unchecked, was that she had to have seven molar teeth removed in August 2009, after she came under the care of Dr. Haran in October, 2008. While Grace's teeth were not decayed, the extremely poor condition of her gums at that stage necessitated those extractions.

10. Grace's general physical health

Preliminary

10.1 This Section reports upon the facts established by the Commission on the overall state of Grace's health and physical well-being, up to the time of her removal from her home with Mrs. X in July, 2009. As is apparent from the evidence reported, the question of Grace's dental health is linked with Grace's general health, but it has been reported separately above for ease of reference.

The Commission's First and Second Substantive Interim Reports

- 10.2 Grace's general state of health in the period preceding and post-dating her move to Family X's up to 2007, as reflected in the reports of the examinations and assessments of her which were arranged over that period, has been reported in the First and Second Substantive Interim Reports.
- 10.3 References to the reports from before Grace was placed with Family X in February, 1989 are set out in the First Substantive Interim Report.⁵⁰
- 10.4 Reports from after the time that Grace was placed with Family X in February, 1989 are reported in the First and Second Substantive Interim Reports.⁵¹
- 10.5 The evidence to the Commission was that Grace was medically examined by Dr. Walsh, Acting Senior Area Medical Officer with the SEHB on two occasions during her childhood, in August, 1992 and May, 1995. These examinations, reported in the First Substantive Interim Report, are referred to further below.
- 10.6 The portrayal of Grace as a person who, despite being diagnosed as being microcephalic, was generally in good health, was reflected in the evidence provided by SEHB/HSE personnel who encountered her over the years that she resided with Family X, reported in the First and Second Substantive Interim Reports (as reported, Grace was not visited by SEHB/HSE personnel between June, 2001 and September, 2007). The Commission did not receive evidence that there were any issues raised with respect to her overall state of physical health in these accounts.

⁵⁰ Grace was assessed by Mr. Enda McGovern, Clinical Psychologist in the Brothers of Charity, on 3rd August, 1989. The contents of Mr. McGovern's report are discussed at paragraphs 9.23 to 9.30 of Chapter 5 of the Commission's First Substantive Interim Report. A psychiatric assessment of Grace was conducted on 18th August, 1989. The notes of that assessment are reported upon at paragraph 9.37 of Chapter 5 of the First Substantive Interim Report.

⁵¹ Following a medical examination of Grace on 13th August, 1992 at the home of Family X, Dr. Walsh produced a "*physical examination report*" dated 13th August, 1992. This report is referred to in detail at paragraphs 10.69 to 10.75 of Chapter 5 of the Commission's First Substantive Interim Report. Dr. Walsh carried out a second medical examination of Grace on 24th January, 1995 and produced a medical report in respect of Grace, the contents of which are discussed at paragraph 10.69 and paragraphs 10.76 to 10.77 of Chapter 5 and paragraphs 2.25 to 2.32 of Chapter 6 of the First Substantive Interim Report. Dr. Walsh also provided details in relation to her 1995 examination of Grace in a letter she wrote to Residential Facility B, dated 28th February, 1995, referred to at paragraph 9.69 of Chapter 5 and paragraph 2.38 of Chapter 6 of the First Substantive Interim Report. On 29th May, 1995, a clinical psychologist prepared a report in relation to Grace following an assessment of her conducted on 13th April, 1995. The contents of this report are discussed at paragraphs 2.45 to 2.54 of Chapter 6 of the First Substantive Interim Report.

- 10.7 This Section also reports on the evidence of Grace's general practitioner, Dr. F, with respect to her attendances at his practice and her state of health over the period that she lived with Family X.

Medical examinations of Grace

Dr. Elizabeth Walsh

- 10.8 Dr. Walsh examined Grace for the first time in August, 1992. Her report of this examination, dated 13th August, 1992, is referred to in detail in Chapter 5 of the Commission's First Substantive Interim Report.

Examination by Dr. Walsh in August, 1992

- 10.9 In or around June, 1992, Dr. Walsh agreed to do a medical examination of Grace in connection with an application that had been made for a place for her in Residential Facility A. At that time, Dr. Walsh had never met Grace, whether in connection with her day-to-day care or otherwise, and had never been out to Family X's house. Before she conducted the examination, Dr. Walsh was given a synopsis of a social report on Grace by the Children's Officer with the SEHB, Ms Greaney (which report had been prepared as part of the application to Residential Facility A), and had also read Grace's file.
- 10.10 Dr. Walsh visited Grace at home on 13th August, 1992 and examined her, following which she prepared a "*physical examination report*". In her report, Dr. Walsh set out general information about Grace's state of health under certain specific headings such as height, weight, vision, hearing, teeth, immunisation, and medication. Grace was described as being five feet tall and weighing five stone.
- 10.11 Dr. Walsh told the Commission that she recalled that Grace presented as a slim, petite child. While Dr. Walsh referred in evidence to Grace's having a birth weight of four pounds, that was incorrect because she actually weighed 6.74 lbs. at birth. In any event, Dr. Walsh did not perceive Grace as being underweight when carrying out her medical examination. Dr. Walsh gave evidence that comparative standards of height and weight for children with microcephaly did not exist, unlike for children with certain other disabilities. Dr. Walsh said that she did not have sufficient information to align Grace with her family size but added that, by and large, 7% to 9% body weight

was in the head. She was mindful that Grace had severe microcephaly and, therefore, had a very small head. She said that, accordingly, on an ordinary “body mass index” scale for the average population, Grace would be below average.

10.12 Dr. Walsh’s report stated that Grace’s teeth suffered from poor hygiene and that she had inflamed gums. Dr. Walsh told the Commission that she advised Mrs. X on toothbrushing techniques for Grace during the course of her visit. Mrs. X recalled someone coming out to visit Grace but could not recall that it was Dr. Walsh.

10.13 Dr. Walsh’s report went on to say that Grace suffered from “*severe mental handicap*” but was fully ambulant and fully continent. Dr. Walsh noted that Grace appeared to see well and could hear a softly spoken voice.

10.14 Dr. Walsh described Grace in her report as being “*well-behaved*”, “*cooperative*”, and stated that her “*general health is very good*”.

Examination by Dr. Walsh in January, 1995

10.15 Dr. Walsh examined Grace for a second time in January, 1995 and her report of this examination is referred to in detail in Chapters 5 and 6 of the First Substantive Interim Report.

10.16 Dr. Walsh’s second examination of Grace took place on 24th January, 1995 at Newgate Clinic in Waterford. This examination was conducted at the request of Ms O’Sullivan, the Public Health Nurse. There were three reasons for it, namely:

- (1) review of Grace’s current placement;
- (2) possibility of alternative residential placement; and
- (3) possibility of day placement.⁵²

10.17 Dr. Walsh prepared a report on foot of this examination. She concluded it by recommending that an eye appointment and a psychological assessment be

⁵² The document containing the results of this examination bore a handwritten note indicating that those were the reasons for the review.

arranged for Grace; that her placement be reviewed, as her foster parents were elderly; and that she have a full blood count done.

- 10.18 Dr. Walsh recalled in evidence that the review was conducted *“to review [Grace’s] current placement in view of the age of the foster parents, but as well there was a point along the way where I became aware that [Mr. X] had health issues.”*
- 10.19 Dr. Walsh took a history of Grace’s health from Mrs. X. She recalled being told by Mrs. X that Grace’s teeth bled if brushed but that she did not go to the dentist. Grace was referred by Dr. Walsh to a dental clinic that was running in the same building that day to receive advice in relation to brushing techniques and dental care.
- 10.20 Dr. Walsh’s notes set out that Mrs. X reported that Grace’s general health was good and that she had not been in hospital in the six years during her placement with Family X. Grace was non-verbal but could feed herself and drink from a cup. Mrs. X reported that Grace wore nappies at night and was toilet trained by day. Generally, Grace slept from eight o’clock in the evening until half past seven in the morning.
- 10.21 Mrs. X had no recollection of this examination when giving her evidence to the Commission.
- 10.22 On physical examination, Dr. Walsh told the Commission that Grace’s lower limbs were cold to the touch but that she looked well. Grace weighed five stone four pounds and was four feet ten inches tall. Dr. Walsh stated that *“she presented as a young person with a severe mental disability. She had microcephaly. She was ambulant and she had no behaviour problems at the clinic.”* Dr. Walsh reported that Grace’s cardiovascular system and respiratory system were normal.
- 10.23 Dr. Walsh recommended that Grace be referred to the eye clinic and that a psychological assessment be undertaken. In addition to this, Dr. Walsh recommended a review of Grace’s residential and day placements which, she outlined, would follow on from the psychological assessment which had been requested.
- 10.24 Ms O’Sullivan, who was present for this medical examination appointment, told the Commission that she could not remember any concerns but would have discussed

the matters raised in the report with Dr. Walsh at the time. Ms O’Sullivan described Grace as having “*acceptable levels of cleanliness*”.

10.25 In her letter dated 28th February, 1995, Dr. Walsh wrote to Residential Facility B in connection with trying to find a suitable residential placement for Grace and stating that “[Grace] *is of good behaviour and presents no management difficulties. Her general health is good.*”

10.26 Dr. Walsh’s evidence to the Commission with respect to Grace’s general state of health accorded with her above two reports.

Grace’s general practitioner

Preliminary

10.27 From the medical records available, Grace first attended Dr. F, general practitioner, in May, 1990. As reported above, Dr. F was Grace’s general practitioner up until his retirement in 2011. His son, Dr. G, worked alongside him in the practice for a number of years before taking over the practice when his father retired. Dr. G subsequently became Grace’s general practitioner for a period and he first examined Grace in October, 2008.

10.28 Aspects of the evidence provided to the Commission by Dr. F and Dr. G are also reported, where relevant, in other chapters of this Volume.

Dr. F

10.29 In his evidence to the Commission, Dr. F said that he knew that Mrs. X was a foster carer and that it was she who brought Grace to the clinic most of the time, although he said that Grace was occasionally brought in by Mr. X. Dr. F said that he thought that the relationship between Grace and Mrs. X was “*very good*”. He told the Commission that Mrs. X was caring towards Grace when she was in his surgery and that their relationship seemed to be a normal one.

10.30 Dr. F said that he always regarded Grace as a child, even when she became an adult, saying “*I suppose like most of my patients she behaved what I would have*

considered normally with a vulnerable child, as I always regarded [Grace] as a child, even though she was an adult later on."

- 10.31 Dr. F said that he believed Mrs. X was a good historian with respect to Grace's symptoms. Mrs. X was also a patient of his practice, so he knew her reasonably well.

Grace's presentation

- 10.32 In his evidence about how Grace presented to him, Dr. F said that, if he had had any concerns with respect to her, he would certainly have written them down. He did not have any concerns apart from addressing the issues with which Grace presented.

- 10.33 With respect to his examinations, Dr. F gave evidence that he would have examined Grace's chest and back when he was testing her lungs and heart, and that he never saw any marks on her in the course of his examinations. He told the Commission that, if there were any marks or bruising on Grace, he would have recorded them in his notes. Dr. F also said that Grace's clothes were not removed for examinations.

- 10.34 Dr. F told the Commission that he always thought that Grace was "*well groomed and well turned out*" and he did not form any negative impression with respect to her presentation.

- 10.35 There was no evidence of any visits to the general practitioner between January, 2001 and October, 2008, apart from attendance for the flu vaccine, referred to below. When he was asked if there was anything unusual about the regularity of Grace's visits or the severity of the illnesses she was suffering from over the course of approximately 20 years, Dr. F said there was not. He referred to an episode of whooping cough (referenced below) but went on to say that "*lots of people got whooping cough in those days*". When he was asked for his opinion as to whether, on review of his notes, Grace was being monitored and adequately cared for generally and in terms of the regularity with which she was brought to the surgery, Dr. F said "*I would imagine so, yes*".

Grace's visits to Dr. F's surgery

- 10.36 Dr. F did not have an independent memory of Grace's coming to visit him on the specific occasions reported, save where noted in the paragraphs below. His evidence

was generally given in association with what he interpreted from his notes and records. Mrs. X had little memory about the visits or the details of attendance with Grace at the general practitioner in the course of her evidence to the Commission.

The year 1990

10.37 There were records of three visits by Grace to the general practitioner in 1990. These visits were on 31st May, 1990, 5th September, 1990, and 17th September, 1990.

10.38 On 31st May 1990, following examination, Dr. F recorded: “*Teeth crowding - Dentist. H/S [heart sounds] ok. Lungs ok. general condition ok.*” Neither Dr. F nor Mrs. X could remember why Grace was brought to the surgery that day.

10.39 Regarding the visit on 5th September, 1990, Dr. F’s note recorded that he examined Grace and noted as follows: “*Right Purulent Nasal discharge ? Foreign body. Throat ok, glands ok. TM ok, treatment Septrin adult suspension.*” In evidence, Dr. F said that, from his notes, it was apparent that Grace had a very profuse nasal discharge, which he thought might have been caused by a foreign body. Dr. F told the Commission that, in his experience, children tended to stick all kinds of things up their noses. He noted that he had checked Grace and determined that it was not a foreign body. Dr. F confirmed that Grace’s eardrums, throat, and lungs were okay, and that he had given her a prescription for *Septrin* which, he said, was the most common, broad-spectrum antibiotic used in those days.

10.40 With reference to a visit on 17th September, 1990, Grace was brought to Dr. F suffering from an infection. His note from this visit read: “*Gingivitis +++ Decay ++*”. Dr. F explained that this meant that Grace had a very severe gum infection, for which he gave her two antifungal agents.

10.41 There was no visit to Dr. F recorded for the years 1991 or 1992. As reported above, Grace was medically assessed by Dr. Walsh in August, 1992.

The year 1993

10.42 There was a note of one visit in Dr. F ’s records in 1993. On 3rd July, 1993, Grace attended Dr. F suffering a “[c]hest infection, wheezy cough ++, lungs ok, ENT ok”. Dr. F prescribed *Septrin* adult suspension. Dr. F told the Commission that Grace had

a chest infection with a wheeze. He said that the reason he wrote “*wheezy cough*” in his notes was because although her lungs were clear clinically when he examined them, she was coughing in front of him and it was a very wheezy cough. Dr. F said in evidence that this ailment was as “*common as dishwater*”.

The year 1994

10.43 There was one entry made in Dr. F’s records in 1994 relating to Grace. Dr. F told the Commission that, from his notes, it was possible to say that, on 11th March, 1994, Mr. X came to the clinic and told him that Grace had a severe chest infection. Dr. F prescribed an antibiotic. During his evidence, Dr. F explained that diagnosis without a patient physically present was a regular occurrence in general practice if one knew the patient well.

The year 1995

10.44 There was no visit by Grace to the general practitioner recorded for 1995.

The year 1996

10.45 There were two recorded visits by Grace to the general practitioner in 1996, namely 15th November and 16th December, 1996.

10.46 Dr. F’s note of the visit on 15th November, 1996 stated: “*Gingivitis ++ and change in personality +++ over the past 3 weeks, crying / laughing uncontrollably, [prescribed] Septrin 7.5 mls.*” Dr. F told the Commission that he took this history from either Mrs. or Mr. X, who had brought Grace in, explaining that he would not have known it otherwise. Mrs. X had no memory of this visit and could not assist with regard to the history given.

10.47 There was, however, a corresponding note made by Day Service Provider A for 15th November, 1996. This stated as follows: “*Phone call from [Mrs. X] re [Grace]. Brought to doctor in relation to previous call from [staff]. [Grace] has gingivitis, very bad bleeding from gums and mouth sore.*”

10.48 Dr. F saw Grace again on 16th December, 1996. On that occasion, he noted “*Cough ++. Listless and off food, O/e Moist cough ++ lungs ok, TM [tympanic membranes of*

the eardrums] *ok*, *Throat ok*, *sinus ok*". Dr. F prescribed *Amoxil* adult suspension and a tonic called *Vivioptal*. Dr. F told the Commission that Grace had a "*fairly common*" chest infection. He gave her a different antibiotic, *Amoxil*, because it was the middle of winter and she had a couple of infections.

The year 1997

- 10.49 There were two recorded visits to the general practitioner in 1997, with possibly a third visit in February, 1997. The recorded visits were on 26th June, 1997 and 12th August, 1997.
- 10.50 A document prepared by Mr. M in 1997, following his having spoken with Mrs. X, noted that Grace's last check-up with her general practitioner was in February, 1997 for mouth ulcers. The Commission received no written record of such a visit from Dr. F. Mrs. X had no recollection about it and Dr. F could only recall visits based on his written records.
- 10.51 Dr. F saw Grace on 26th June, 1997. He noted "*? pharyngitis ++ Cough + moist, fever +, glands +, lungs ok*". Explaining this note, Dr. F said that, rather than tonsillitis, Grace had quite a marked red throat, was feverish, and had a few glands around her throat. He prescribed *Septtrin*. Dr. F said that, on that occasion, Grace's lungs were clear and that this was a "*very common*" infection, in wintertime particularly.
- 10.52 On 11th August, 1997 Nurse N, the Nurse Manager in Day Service Provider A, made a note that Grace's abdomen appeared to be distended that morning. It appears from the note, reported upon below, that she contacted Mrs. X about this. Mrs. X had no memory of this contact when giving evidence to the Commission.
- 10.53 Dr. F's notes showed that Grace was taken by Mrs. X to see Dr. F the following day, 12th August, 1997. Dr. F's note of the visit stated that he was "[t]old her abdomen was distending by nurse in [the day centre]. O/e '*pot*' postural." During his evidence, Dr. F said that, when he examined Grace on that occasion, all he could find was what he termed a "*pot belly*". Dr. F also observed that Grace was inclined to sit in a particular manner and that, if she straightened up, the swelling disappeared.

The year 1998

Mr. M contacts Dr. F

- 10.54 On 12th January, 1998, Mr. M wrote to Dr. F, requesting referral letters to a community ophthalmologist and an audiologist, so that Grace could be assessed for both sight and hearing. With reference to this in his evidence, Mr. M said that the referrals were being arranged because Day Service Provider A had come into a sum of money and was able to afford to make referrals. Mr. M told the Commission that he did not receive a response from Dr. F. Dr. F said that, from his records, he did not send one. There was no evidence that either of these referrals was followed up at any stage.
- 10.55 There was one recorded visit of Grace to the general practitioner in 1998. She was taken by Mrs. X to Dr. F on 24th February, 1998. Dr. F's note recorded that the day service wanted Grace checked because of an issue to do with her abdomen. On examination of Grace's abdomen, Dr. F again concluded that the issue was postural. He noted "*Abdomen [protuberance] – reassured*". No abnormality was detected. He also noted "*O/e Abdomen NAD, UTI (wetting), MSU sent...*" Dr. F prescribed *Seprin*.
- 10.56 When considering his note of that visit, Dr. F said that there was a possibility of a urinary tract infection ("UTI") for the simple reason that Grace was wetting herself, when he thought that she probably had not been doing that up to that point. He said that, with a new symptom, particularly incontinence or wetting, he would either rule out or confirm a UTI. Dr. F said that the urine sample came back normal; there was no infection. Dr. F also told the Commission that he presumed that the wetting was connected to Grace's disability.

The year 1999

- 10.57 There were two recorded visits of Grace to the general practitioner in 1999, on 15th January, 1999 and 18th October, 1999.
- 10.58 On 15th January, 1999, Grace was seen by a locum doctor at Dr. F's practice. Grace had a gum infection, for which the locum prescribed *Flagyl* and penicillin. Dr. F told the Commission that, although he would not describe it as a severe infection, the locum doctor had given two antibiotics, which he said meant that it must have been a

significant infection. Dr. F said that Grace was prone to these things because of the issues to do with her teeth.

10.59 On 18th October, 1999, Grace was seen by Dr. F who recorded: “[Pyorrhea] and gingivitis +=, [foetor] ++, *behaviour disturbance with it*. [Prescribed] *Flagyl and Septrin*.” Dr. F said that Grace had a significant infection, with very inflamed gums and pus coming out of them between her teeth. There was a marked smell (foetor) off her breath. With respect to behavioural disturbance, Dr. F said that he could see from the notes that he had not been able to examine Grace or approach her on that occasion. Grace became disturbed when he was examining her on that particular day. He said that this was the only time that he had any difficulty examining her.

10.60 This infection was partially responsible for Grace’s inability to attend her day placement for the rest of 1999. In this regard, on 22nd October, 1999, CW4 in Day Service Provider A noted that Grace had been out sick since 18th October, 1999 but that they had received a message to say that she should be returning on 26th October, 1999. On 22nd November, 1999, a note from Day Service Provider A recorded that Mrs. X had telephoned CW1 to inform her that Grace was still “*under the doctor*” and also that Mrs. X’s aunt was visiting from England and that Grace would be kept at home until after Christmas.

The year 2000

10.61 There were four recorded visits of Grace to the general practitioner in 2000. These were in connection with whooping cough.

10.62 On 30th June, 2000, the locum doctor at Dr. F’s clinic was consulted by Mrs. X about Grace’s having a “[c]onstant cough with whoop”. The locum prescribed *Klacid* and *Delsym* for 5/7 days. Grace did not attend the clinic on that occasion.

10.63 The locum was contacted again on 3rd July, 2000 by Mrs. X and told that the cough still persisted. The locum prescribed *Exputex* cough medicine for Grace, over the telephone. Grace did not attend the clinic on that occasion either.

10.64 A week later, on 10th July, 2000, Grace was brought to see Dr. F who recorded: “*Whooping cough. Still cough +++ Fever +=, Vomiting ++ O/E Lungs ok, facial flushing, HR 86, [prescribed] Distaclor 250 [for] 7 days and steam and paracodin*”.

10.65 In his evidence, Dr. F said that whooping cough was a clinical diagnosis and that there was no test for it. Working from his notes, Dr. F said that he based his diagnosis on Grace's history. At that stage, he said, Grace was coughing for ten days. Based on his notes, Dr. F said that, when Grace presented to the clinic, she had an "awful cough" and "quite a high fever". She was vomiting and, on examination, she had a flushed face. He said that her lungs being clear was what he would have expected in whooping cough, in that it was a specific type infection. Dr. F said that his treatment for coughs, as distinct from a lot of other doctors, was to inhale steam. He prescribed *Distaclor* as a different antibiotic than the one Grace had had the first day and he said that *Paracodin* was a powerful cough suppressant. Dr. F said that he would not use it except in whooping cough or in cancer of the lungs, where a patient could not stop coughing. Dr. F described the whooping cough that Grace was suffering from as "severe".

10.66 On 29th August, 2000, Dr. F noted: "*Coughing spasms 3 - 4 a.m. nil [else] O/E lungs ok Paracodin 5 mls nocte pro tem.*" From the note, Dr. F said that Grace's cough was getting better but that she still had a nocturnal cough around that time, which he said was quite common in any infection. She had no other symptoms. Her lungs were clear and Dr. F said that he told Mr. X or Mrs. X to give her *Paracodin* as necessary at night; for example, if she had been coughing the previous night, then they were to give it to her the following night and so on. Dr. F said that the whooping cough was basically gone at that stage. He explained that a person with a dose of whooping cough could have an irritant cough without infection for a long time afterwards.

The year 2001

10.67 There were two recorded visits by Grace to the general practitioner in 2001.

10.68 On 20th January, 2001, Grace was examined by a locum doctor. She had a chesty cough, although her chest was clear. She had a chest infection and was prescribed an antibiotic (*Amoxicillin*).

10.69 The second visit was for the flu vaccine, referred to below.

Visits for the flu vaccine – 2001, 2002 and 2003

10.70 The records from Dr. F's surgery indicated that Grace had been brought to the surgery to receive the flu vaccine from a nurse in the practice in October, 2001, and in 2002 and 2003. Mrs. X brought Grace to the surgery for this purpose. The Commission did not have any evidence of Grace's having had a flu vaccine in later years.

The year 2007

Mr. Smith's conversation with Mr. M

10.71 Shortly after Mr. Smith became involved in Grace's case in 2007, he spoke with Mr. M, Manager of Day Service Provider A. Their communication on 18th September, 2007, is reported in the context of the management of Grace's case in Chapter 1 of Volume 1.

10.72 As reported, the purpose of the telephone conversation was for Mr. Smith to clarify on which days Grace was missing from Day Service Provider A and the reason for her absence on them. Mr. Smith recorded that Mr. M advised him that he had been told by Mrs. X that the reason for Grace's missing those days was because she was *"prone to coughs and colds."*

10.73 Mr. Smith was sceptical of this and, in his evidence to the Commission, he said that *'this business about having possible cough and colds and things like that and whether she did have coughs and colds and whether or not she went to the doctor, it all seemed to be a bit of a – you know it didn't seem to ring true with me that there would be particular days she didn't want to go on the bus or, you know, so forth'.*

10.74 Mr. Smith's scepticism on this issue was not misplaced, as reflected in the Commission's findings on the question of Grace's absences from her day placement.

Mr. Smith's conversation with Dr. G

10.75 Mr. Smith also spoke with Dr. G on 18th September, 2007 and learnt that, according to the records of the practice, Grace had not been to the surgery during the previous five years.

10.76 In his evidence, Dr. G confirmed that he had told Mr. Smith that he had not seen Grace recently. As reported above, Grace had been taken to the surgery for the flu vaccine and, from a reading of the surgery's records, the last entry on Grace's file was dated 10th October, 2003, when she received the flu vaccination from a nurse. The previous occasion when Grace was examined by a doctor was on 20th January, 2001.

The year 2008

10.77 There were no records of any further visits to the surgery until Grace was taken by Mrs. X to be seen by Dr. G on 8th October, 2008.

10.78 Dr. G said that he had not heard of Family X before he was contacted by Mr. Smith in September, 2007. While Mrs. X and other members of Family X were patients of the practice, he himself had not met any of the family at that stage. He said that he was pretty sure that the first time he met Mrs. X and Grace was in 2008.

10.79 By way of background to this, on 21st July, 2008, Ms D had contacted Mrs. X regarding Grace's urinary incontinence and, in the course of their discussion, had asked her to take Grace to the doctor to check this. As referred to above, and in Section 3 (Context) in particular, incontinence was an ongoing issue for Grace and it continued to be an issue after she was moved into a residential placement in July, 2009. This is a matter that is also referred to in Chapter 6 of this Volume. At the time that she asked Mrs. X to take Grace to the doctor to check incontinence, Ms D did not have the same familiarity with Grace's ongoing incontinence issue as she did later.

10.80 Arising from the above, Mrs. X brought Grace to Dr. G's clinic on 11th August, 2008. Grace was seen by the practice nurse who recorded that Grace was "[g]enerally well. No problems has started menses. Attends [Day Service Provider A] daily. BP 110/70. Cannot take bloods as will not let me get near her" (Grace was almost 30 years of age by this time).

10.81 On 28th August, 2008, Dr. G noted that he received a telephone call from Mr. Smith. He noted that he was told that the HSE's Social Work Department was concerned about Grace's environment and worried that she might be neglected. Dr. G was told that Grace had a bruise around her eye recently and had been brought to the

Emergency Department in Waterford Regional Hospital by Mr. Smith (the hospital visit has been referred to above at paragraph 5.49 *et seq.* and is also reported upon in Chapter 2 of this Volume). He was also informed that Grace attended a day centre and that, a few months previously, the staff there had noticed what Mr. Smith informed Dr. G looked like friction burns. Dr. G was also informed that Grace had a deformity of her little finger for years and that Mrs. X had maintained that this was present before she took Grace into her care. What Mr. Smith recorded having been told by Mrs. X in that regard is reported upon in Chapter 2 of this Volume.

10.82 As reported in Chapter 7 of Volume 1, Mrs. X told the Commission that she did not remember hearing about Grace's hand being x-rayed at the hospital and an old injury found on her finger. She said that she never saw that injury over the years that Grace had been living with her. She said that Mr. Smith must have told her about the injury to Grace's finger, but she could not remember when that was.

10.83 Having been requested to do so, Mrs. X brought Grace to Dr. G on 8th October, 2008 for an overall check-up. Dr. G's record of this appointment was as follows:

"Checkup, not seen by me before, with foster Mum who she will be with for 20 yrs in January, has been with dentist today. [O]nly problem at present is that toe nails have been brittle + thickened for some time, wears nappy at night, uses toilet during day [time] without difficulty. attends [Day Service Provider A] 5 [days] per [week] during daytime, was going less often up to [a] few mths ago until social work dept decided [that] she needed to go more. o/e well kempt, peri, fundi - no cataracts, ears wax ++ - advised olive oil, throat N, ++ Lns p 80 reg cvs N, resp N. abd N locomotor - walks without difficulty + moves all limbs."

10.84 In his evidence, Dr. G said that Grace was "well-kempt", denoting, in his words, *"somebody who looks like they are looked after, their hair is done, they look clean, their clothes are clean, they are dressed appropriately."* Dr. G said that he did not have any concern about neglect. However, he acknowledged that he did not know if Grace was well-kempt all of the time, since he only saw her on this visit, which was pre-arranged. He told the Commission that *"[o]n the day I saw her she looked fine, I physically couldn't find anything, and there was no marks on all the areas of skin that I saw"*.

- 10.85 Dr. G noted that Grace's pupils were equal and reactive to light and that she had no cataracts. She had ear wax and he advised using olive oil to soften it. Examination of her throat was normal. Dr. G said that he could feel a "*fair few*" lymph nodes in her neck. He said that these tended to swell up if one contracted any upper area infection. Grace's pulse was 80 and regular. Her cardiovascular system was normal. He noted her respiratory system and abdomen as normal on examination.
- 10.86 Regarding his note that Grace "*walks without difficulty + moves all limbs*", Dr. G said that she was able to walk in and out of the room and to move all of her limbs without any difficulty; there was no obvious weakness. With regard to how Grace behaved during this examination, Dr. G said that she must have been well-behaved and cooperative and that, if she had been difficult to examine, he would have written that in his examination notes. He said that the fact that he was able to look into her eyes and examine her ears meant that she had not been difficult to examine.
- 10.87 Dr. G said that he asked Mrs. X if there was anything physically wrong with Grace and whether there anything that she was concerned about or that she needed him to look at, and that the only matter that she raised was the condition of Grace's toenails. He said "*the other things were just things I would have asked just routinely about continence, and that, and [Mrs. X] may have just offered that to me*".
- 10.88 Dr. G examined Grace's upper chest, her back, her abdomen and the lower part of her legs and said that he did not see anything untoward, be it scratches or bruises. In this regard, he noted during his evidence that, because he was aware that the HSE wanted to move Grace, if there had been anything like that, he would have been sure to have recorded it.
- 10.89 Dr. G told the Commission that he did not have any feeling that Mrs. X was having a difficult time managing Grace. He said that there was no issue between the two of them. He said that Grace was quite easy to examine and he surmised that Grace was obviously comfortable in Mrs. X's presence.
- 10.90 Dr. G said that he did not refer Grace onwards to any consultant or specialist arising from his examination. He did not require to see her by way of follow-up and did not raise any concern about her general health or her condition of incontinence, nor did he suggest any medical intervention in that regard. He was aware that Grace had been referred to the dentist (Dr. Haran) and had been to see her that day.

10.91 On 28th October, 2008, Ms Browne prepared a note to file regarding a meeting with Mrs. X in July, 2008. Her note recorded that she questioned Mrs. X about taking Grace to her doctor. Mrs. X said that she only took Grace to the doctor when she was sick. Ms Browne asked her if she had ever taken Grace to the doctor when she missed her day service and Mrs. X said that she did not consider that as being sick, that Grace only had a cold. Ms Browne asked Mrs. X if she had ever taken Grace to the doctor when she had bruises and Mrs. X did not answer the question. Mrs. X said that Grace scratched herself and that, when that happened, she would cut Grace's nails in an attempt to stop her from doing that.

The year 2009

10.92 The next documented involvement of a general practitioner in Grace's care was in July, 2009, when Ms D contacted Grace's general practitioner about sending a urine sample for further tests. On 8th July, 2009, such a sample had been taken from Grace at Day Service Provider A which showed a *"raised PH level and blood"*. Mrs. X then brought a urine sample to Dr. G's clinic for testing. The results of the tests were clear.

10.93 This was a week before Grace was moved into a residential placement. The circumstances of this move are reported in Chapter 20 of Volume 1 and the consequences for Grace are reported in Chapter 4 of this Volume.

Findings on Grace's general physical health

10.94 The Commission is satisfied that, from the evidence over the years that Grace lived with Family X, she was generally found to be in good health. This was apart from the significant issues with respect to her teeth and gums, reported upon above.

10.95 The evidence established that Grace suffered common ailments, such as colds, coughs, infections, and also sore throats, which were sometimes related to her gum problems. On occasion, as reported above, she was taken to her doctor with respect to these ailments or the doctor was contacted for advice on treatment. Clearly, and not unexpectedly, Grace was not taken to the doctor every time she was sick or had a cough, cold, or sore throat. In this regard, Mrs. X's position, as related to Ms Browne on 28th October, 2008, was that she did not consider that Grace needed to attend the doctor if she only had a cold or the like.

- 10.96 There was no evidence that Grace was taken to the general practitioner's surgery between October, 2003, when she attended for the flu vaccine, and October, 2008, when she was taken to see Dr. G for a general check-up. As reported above, Grace was regularly absent from her day placement over these years, with reasons sometimes given that she was sick. As reported above, the Commission is satisfied that this was sometimes a reason given by Mrs. X as an excuse to keep her at home. The Commission does not rule out that Grace was sick at home on some occasions for ailments that did not necessitate a visit to the doctor. However, insofar as possible need for attendance at the doctor is concerned, the Commission did not receive evidence of Grace's having suffered significant ill health over this period as to warrant her absence from her day service.
- 10.97 There was no evidence from Grace's general practitioner, as reported above, that he had any concern that Grace was the subject of neglect. No medical concern was expressed about Grace's weight or that she was not well nourished on the occasions that she attended the general practitioner's surgery.
- 10.98 The evidence with respect to Grace did not establish that her general physical health was, in fact, subject to neglect when residing with Family X in the care of Mrs. X.

11. Overall findings

- 11.1 The impact upon Grace of neglect found in aspects of her care has been reported in the relevant Sections set out in this Chapter. The Commission is satisfied on the evidence that Mrs. X was negligent in these aspects of her care for Grace. The neglect so found was such as to impact negatively upon, and to breach Grace's general well-being and dignity. It is important to note that the facts established with respect to the care that was provided by Mrs. X to Grace (notwithstanding the areas of deficit and the poor standard of Grace's care found in some aspects) are also reported throughout this Volume.
- 11.2 The Commission has already reported upon the fundamental failure of the SEHB and the HSE to monitor Grace's care properly in her placement in the Commission's First and Second Substantive Interim Reports. As reported in this Chapter, there was no evidence of any substance of any, or any effective, oversight of the manner in which Grace's day-to-day care was provided. There was no evidence to the Commission that the manner in which Mrs. X provided Grace's care, including matters of Grace's

presentation, clothing, personal hygiene, dental or medical care or attendance at her day placement, was ever queried by SEHB or HSE personnel with Mrs. X or Mr. X. For instance, the concerns which Ms Jones referred to during her evidence – to the effect that, when handing over Grace’s case to Ms Leyshon in 1999, Grace was “*close to the line of needing extra care in terms of hygiene*” - were never addressed by the SEHB or the HSE directly with Mrs. X, while leaving Grace in her placement.

- 11.3 The Commission is satisfied that the general absence of oversight and monitoring of Grace in her placement by the SEHB and the HSE, save for particular instances identified above, in particular before Mr. Smith's intervention in Grace's case in August, 2007 (reported upon in Part 1 of Volume 1 of the Commission’s Final Substantive Report) inevitably permitted the areas of neglect established in the evidence to develop or persist over time, more or less unchecked. This was a fundamental failure of their duty of care to Grace in the circumstances.

END

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CHAPTER 4

1. Introduction

- 1.1 Having regard to Terms of Reference V. a) and VIII. a) and to the definition of “abuse”¹ contained in the Terms of Reference, the purpose of this Chapter is to consider and report upon the evidence provided to the Commission in Phase One of its investigations on the question of whether Grace was subjected to abuse of a sexual nature while living with Family X. This was a central issue to be investigated under the Terms of Reference set for the Commission.
- 1.2 As with all other aspects of potential areas of abuse of Grace considered by the Commission, in focusing on evidence gathered by it relevant to this question in Phase One of its investigations, the Commission had regard to the facts established in other aspects of Grace’s care. Inevitably, there is, therefore, crossover between some matters reported in this Chapter and those reported in other chapters of this Volume.
- 1.3 Along with other strands of evidence considered in this Chapter, the Commission considered evidence with respect to certain aspects of Grace’s behaviour for the purpose of establishing whether or not they provided evidence that Grace had been subjected to sexual abuse. These aspects of Grace’s behaviour included her tendency to strip off her clothing, incidents of apparent “sexual frustration”, and other behaviours that certain witnesses considered capable of having a sexually underlying cause.
- 1.4 An important aspect of the evidence heard by the Commission concerned the contrast between Grace’s maladaptive behaviours (*i.e.* behaviours that interfere with an individual’s activities during daily living or his or her ability to adjust to and participate in particular settings) before she was moved into a residential placement in July, 2009, on the one hand, and those which occurred after the move, which were of a different order and greatly intensified, on the other. This is reported upon in detail below.

¹ The term “abuse” is defined in the Terms of Reference at XI, “*Interpretation*”.

- 1.5 The Commission considered it unwieldy to separate the maladaptive behaviours displayed by Grace which certain witnesses considered to be capable of having a sexually underlying cause from all of the maladaptive behaviours that she displayed. That is to say, some aspects of the concerns on the part of witnesses to Grace's behaviours having a potentially sexual cause needed to be reported within the broader context of her maladaptive behaviours, whether of potentially sexual cause or not.

The absence of direct evidence

- 1.6 Before reporting upon the above matters, it is important to report that there was no direct evidence provided to the Commission throughout its investigations into Grace's care of any date or occasion upon which she was alleged to have been sexually assaulted by any person(s), whether identified or not. Further, there was no medical evidence to the Commission that Grace had been subjected to sexual abuse at any time. During the course of the Commission's investigations, no allegation of a specific occasion of sexual abuse of Grace was made.²
- 1.7 The fact that Grace was unable to give any evidence to the Commission on this question, either directly or indirectly (as was the case with other aspects of her life), was a significant evidential challenge. In this regard, Grace could neither tell the Commission that she had been subjected to sexual abuse, if that was so, nor could Grace tell the Commission that this had never occurred, if this was the case. The Commission was cognisant of the realities associated with sexual offending and the fact that it generally occurs in the absence of witnesses. This observation should not, of course, be taken as implying that sexual abuse did, in fact, occur, but is rather an acknowledgement of the nature of offending of this kind.
- 1.8 In considering the evidence concerning the question of whether Grace was subjected to sexual abuse, matters of suspicion and speculation required to be distinguished from those of fact established on the evidence to the Commission on this issue.

Previous allegations

² Mr. Smith's concerns that gave rise to Grace's being taken to hospital for examination in March, 2009 are considered in detail later in this Chapter.

- 1.9 It should be noted at the outset that the concern of Mr. Smith, HSE Social Work Team Leader in Disability Services, Waterford Community Care, after he became involved in Grace's case in 2007, as to whether Grace had previously been subjected to, or was at risk of, sexual abuse, arose in connection with the fact that there had been previous concerns about sexual abuse or sexualised behaviours (not of Grace) which were known to the SEHB and related to two children with intellectual disabilities who had stayed at various times with Family X. One child, E.E., had stayed with Family X for a week on three occasions in the 1980s (July, 1984, July, 1985 and July, 1987). Another child, Z.Z., had stayed with Family X over periods of time from 1988 to 1993. This concern about the existence of such previous allegations was an appropriate one for Mr. Smith to have, as a social worker involved in the management of Grace's case.
- 1.10 Insofar as E.E. is concerned, in March, 1996, the SEHB received notification of an allegation of sexual molestation against Mr. X made on behalf of E.E relating to her stay with Family X approximately 10 years previously. The Commission has reported in detail in its First Substantive Interim Report upon the circumstances surrounding the making of that allegation and the circumstances in which it could not be investigated by the SEHB at the time. The Commission has also reported in its First Substantive Interim Report upon what occurred thereafter, the decision to remove Grace from the placement as a consequence of the making of the allegation, the reversal of that decision, and upon the relevant Terms of Reference to be investigated by it concerning the management of Grace's case and her care and protection at that time. As part of Garda investigations in 2014, E.E. gave a statement expanding upon the complaint made on her behalf in 1996.
- 1.11 With regard to Z.Z., in 1992/1993, an investigation was conducted by the Senior Social Worker in the SEHB following concerns communicated to the SEHB with respect to her care, including a concern about sexualised behaviour by her. The position of Grace in the household was not reviewed by the SEHB at the time of, or in the context of, those concerns. In accordance with Term of Reference IV. d), the Commission reports upon the SEHB's investigation of the concerns with respect to Z.Z. in Volume 5 of this report. The failings found by the Commission about the manner in which that investigation was conducted, and the failure to carry out any review of Grace's position at the time, are reported in that Volume.

- 1.12 The Commission has conducted wide inquiries and taken extensive evidence for the purposes of its investigations into Grace's care as reported in this Volume. As set out in the Introductory Chapter to this Volume, the work set for the Commission in Phase One relates to Grace's case and her care. Information with respect to the above cases, together with those of a number of other service users who made, or had made on their behalves, complaints or allegations with respect to their care, will be taken into consideration by the Commission when addressing Part X of the Terms of Reference.

2. Evidence

Layout of evidence

- 2.1 As outlined above, this Chapter examines the question of whether Grace suffered sexual abuse during the time she spent with Family X, which extends over a period from early 1989 till July, 2009. The evidence considered by the Commission in examining these matters broadly covers the following:

- (i) evidence with respect to Grace's behaviours and presentation before her move from her placement with Mrs. X to a residential unit in July, 2009;
- (ii) evidence with respect to Grace's behaviours and presentation after her move from her placement with Mrs. X to a residential unit in July, 2009, including the impact of the move on her;
- (iii) evidence with respect to Grace's home life and living arrangements, including her relationship with Mrs. X and Mr. X and with others in the household; and
- (iv) evidence concerning the circumstances of Grace's attendance at Waterford Regional Hospital on 27th March, 2009.

- 2.2 For the purpose of the Commission's examination, this Chapter is divided into two parts, namely Part A and Part B. Whereas Part A focuses on the period during which Grace lived with Family X, Part B examines Grace's behaviours and presentation in the aftermath of her move to her residential placement.

Medical evidence

2.3 An important feature, common to both Part A and Part B of this Chapter, was Grace's behaviours and presentation. The Commission considers such matters from the perspective of whether or not they could, in reality, be viewed as indicators that Grace had been subjected to sexual abuse. This was an important facet of the Commission's work. In considering these matters, the Commission heard evidence from certain clinical psychologists/psychiatrists who had involvement in Grace's case, both before and after her move in July, 2009, namely:

- Mr. Enda McGovern, Clinical Psychologist, Brothers of Charity;
- Dr. Nan Ferrari, Consultant Psychiatrist, Brothers of Charity;
- Dr. Ali Akhtar Syed, Principal Clinical Psychologist, Brothers of Charity;
- Dr. Maeve Moran, Consultant Psychiatrist, Brothers of Charity; and
- Dr. Shay Caffrey, Consultant Psychologist.

2.4 As will be seen below, the evidence of the relevant medical personnel was of considerable assistance to the Commission in establishing how the move to a residential placement affected Grace, her difficulties in adjusting to and settling into her new environment, and whether there were any indicators from her presentation and behaviours at that time to suggest that she had been subjected to sexual abuse.

2.5 This Chapter will report, where relevant, upon the assessments of Grace by the above clinical psychologists and psychiatrists at different times, upon issues of potential impact on Grace of the proposed move from her placement with Mrs. X, upon issues of attachment and transition that needed to be understood in connection with the proposed move, upon the range of behavioural issues and changes presenting, and upon any concerns arising. In particular, the evidence of the medical personnel reported upon relates to what, if anything, could be interpreted from Grace's presentation or behaviours preceding and post-dating her move into the residential placement in July, 2009.

2.6 As pointed out above at paragraph 1.5, consideration of this evidence with that focus in mind extends to reporting not only upon those maladaptive behaviours of Grace which appeared to some to have a possible underlying sexual cause and as being

indicative of her having suffered abuse, but also upon her co-existing maladaptive behaviours. To do otherwise would lose sight of the overall context in which those behaviours were exhibited or developed.

- 2.7 Treatment in this Chapter of concerns arising from Grace's behaviours includes material changes in her behaviours at certain times. These are considered and reported upon below under headings concerning possibly sexualised behaviours such as "stripping" and "sexual frustration".
- 2.8 In considering the evidence at Part B below about Grace's behaviours and presentation in the period following her move into a residential facility in July, 2009, the Commission will also consider the very traumatic impact that this change in her living circumstances had upon her and her mental health. The sharp and devastating decline in Grace's mental health and well-being following the move from what had been her home for 20 years was a particularly troubling feature of the evidence received by the Commission.
- 2.9 The section in Chapters 2 and 3 of this Volume, reporting upon Grace's general medical history and, in particular, the evidence of Dr. F and Dr. G, should also be read with this Chapter.

Mr. Smith's evidence

- 2.10 The concerns of Mr. Iain Smith, HSE Social Work Team Leader in Disability Services, Waterford Community Care, concerning the question of whether there was evidence of sexual abuse of Grace, are considered below when reporting on the above issues. It is important to note that Mr. Smith's role in Grace's case, from when he first became involved in it in July, 2007, is comprehensively reported upon throughout the chapters of Volume 1 of the Commission's Final Substantive Report.

PART A: Evidence of events preceding Grace's move to residential placement in July, 2009

3. Grace's presentation and behaviours

- 3.1 The Commission will now consider in this part of its report incidents of behaviour pre-dating Grace's move to residential care and assess whether they had an underlying sexual cause and indicated that she had been subjected to sexual abuse.

Stripping

- 3.2 This aspect of Grace's behaviours has been already reported in Chapter 6 of the First Substantive Interim Report, which should be read with this Section. As reported, there was concern about this behaviour, which was raised by Ms Kathleen O'Sullivan, Nurse Counsellor for Parents of Mentally Handicapped Children, by staff in Day Service Provider A, and also by Mrs. X.
- 3.3 Stripping off her clothes was a feature of Grace's behaviour from a relatively early stage. This was reported in 1995, around the time that Grace started to attend her day placement at Day Service Provider A. Grace would sometimes strip in the vicinity of the bathroom in Day Service Provider A, or at the swimming pool on trips there from Day Service Provider A. Mr. M gave evidence that there were two cubicles with toilets in Day Service Provider A and that one of them had a bath in it. The Commission heard that Grace would sometimes strip off her clothes and make a beeline for the bath and just stand by it. The staff took this to mean that she wanted a bath. Mr. M gave evidence that this was not to say that they gave her a bath every time she stripped off. However, he said that they did so if she was in particularly bad form, or if they had the time.
- 3.4 Mr. M said that the staff knew that if Grace was agitated, the instant solution was to give her the things that she loved the most - the bath or brushing her hair - and that doing so would calm her down. He said that Grace loved being pampered and that they had a "*contraption*" for the bath which created bubbles and which Grace loved.
- 3.5 The Commission heard similar evidence from the care staff in Day Service Provider A. CW1 also said that Grace absolutely loved water and used to get very excited about being in the water. She said that Grace was very calm when the staff put her in

the bath and when they washed and brushed her hair. Another member of staff, CW4, also recalled that Grace came off the bus and generally went straight to the toilet. She also recalled that Grace often went to the toilet where the bath was located, stripped off and waited to be put in the bath. She also believed that Grace required to be bathed often as a result of being incontinent on the bus coming in. Insofar as CW2 was concerned, she recalled that, upon coming off the bus, Grace would go in and often strip off and that she took it that Grace wanted to have a bath. CW2 was asked if this continued throughout 2007. She could not recall whether it did or did not, before going on to say "*I am sure it did*".

- 3.6 The involvement of Ms Jones, SEHB Social Worker, has been reported in the Second Substantive Interim Report. Ms Jones, who was Grace's assigned key worker from September, 1997 to February, 1999 when Grace was 18/19 years old, gave evidence that some of Grace's "*different behaviours*" caused her concern. In particular, she highlighted incidents of which she was aware of Grace's at times stripping in Day Service Provider A. However, in her evidence, Ms Jones also pointed out that Grace was not the only person of a similar level of disability that would have displayed behaviours such as these. She distinguished Grace's case by saying that if the behaviour was being exhibited by a child attending primary school who did not suffer such intellectual disability, it would have caused her huge concern, but that it did not do so in Grace's case. She noted that Grace loved swimming and having a bath and that sometimes Grace's stripping might have been an indicator that she wanted to do one of those things.
- 3.7 The concerns with respect to Grace's behaviours of stripping (and head-butting) were known to the health board before Mr. M's report of April, 1996 was received by the board.³ These behaviours were considered to be attributable to Grace's difficulties in adjusting to her changed circumstances. The view of Dr. Elizabeth Walsh, Senior Area Medical Officer, SEHB, was that the behaviours exhibited by Grace when she started to attend Day Service Provider A (including head banging and stripping) were related to that change in Grace's life. This has been reported in the Commission's First Substantive Interim Report.
- 3.8 As reported in the First Substantive Interim Report, the Commission is satisfied that the stripping by Grace was not related to sexualised behaviour.

³ This was a progress report on Grace's first seven months in Day Service Provider A. The circumstances in which it came to be prepared have been reported upon in the First Substantive Interim Report.

- 3.9 Although Grace's regular stripping abated after she appeared to settle in Day Service Provider A, the Commission heard that it was a behaviour that she continued to exhibit from time to time over the years. Day Service Provider A kept a Daily Report Book, the purpose of which was to document how clients got on during the day, what activities they did, and how they ate or drank. If something was concerning, it was documented. The Commission also heard that if Grace had a bruise or a mark, or was incontinent or stripping, this was noted in that book.
- 3.10 Instances of the circumstances of stripping were encapsulated in the following entries in this book for 1999. These are reported here as an illustration of how this behaviour of Grace's was interpreted.
- 3.11 On 2nd February, 1999, CW1 made a note stating "*[a]fter lunch there was a bit of commotion regarding putting [Grace's] clothes back on... She took them off. In order to do so, [Grace] got into the bath.*" Mr. M remembered that Grace used to strip off and, looking at this entry, said that Grace was stripping off to go to the bath.
- 3.12 On 13th May, 1999, CW1 made a note that "*[w]hile a staff member was drying one of the trainee's hair after her bath [Grace] rushed out of the room and into the bathroom. She then took off her clothes. [Grace] was then put into the bath and had her hair washed & brushed & dried. The staff members sent a letter home with [Grace] to say that [Grace] had taken off her clothes and had had a bath.*" The following day, CW1 made a note that Grace was not present with the other service users when the bus arrived in the morning. She telephoned Mrs. X who told her that Grace was "*bold*" for taking off her clothes and so was being kept at home. CW1 made a note stating that "*I explained that when [Grace] does this, we read from this behaviour that she would like to get into the bath.*"
- 3.13 Another incident of stripping behaviour in Day Service Provider A is captured in a note of CW7 of 18th November, 2008 to Mrs. X as follows: "*[Grace] was in very good form today. Lots of laughing and squealing. However, stripped all her clothes off twice in the bathroom. Was also incontinent of urine this morning.*" Mrs. X responded by a note on 19th November, 2008, stating that Grace never took her clothes off at home, apart from when she was told to go to bed. Mrs. X stated that she took the plastic keys from Grace when she did that.

- 3.14 In her evidence to the Commission, CW7 said that she did not recall how regularly this stripping occurred or what reason she attributed to it. CW7 recalled that they would have tried to limit this as much as possible and would attend to Grace straight away when they found that she was stripping. On the question of whether it was concerning and why, CW7 said, *“Well, I suppose, it is an unusual behaviour and we didn’t want her to be exposing herself to other people in the building”*.
- 3.15 The issue of regression following Grace’s absences from the day centre is reported in Chapter 3 of this Volume. Referring to Grace’s behaviours in this regard, Mr. M said that there was a regression every time she came back from an absence. He said that it was almost as though they had *“to climb the mountain”* again. They had to walk her through her routines again, such as toileting times, sitting at the table, all of those things. He said that Grace might have screamed or hit her head, adding that head-banging was a behaviour that could spring out of anywhere, as could stripping off her clothes.
- 3.16 CW2 also referred to this problem of Grace’s regressing and noted that while they did great work with her when she was there, they had to start all over again when she came back after absences. She said that Grace was quite difficult to manage for the first number of days until she settled back down again.

Views of Mr. McGovern

- 3.17 Mr. McGovern also gave evidence to the Commission about his views on the stripping exhibited by Grace. As reported in Chapter 12 of Volume 1 of the Commission’s Final Substantive Report, both he and Dr. Ferrari had seen Grace for the purposes of Mr. McGovern’s assessment of her in October/November, 2008. Mr. McGovern had assessed Grace’s social, emotional and intellectual functioning in 2008 in connection with the plan to move her from Mrs. X’s care into a residential placement. Mr. McGovern had also previously carried out an assessment of Grace as a child in 1989, which has been reported upon in the First Substantive Interim Report.
- 3.18 Mr. McGovern had a meeting with Mrs. X at which Grace was also present on 28th October, 2008. His notes of that meeting referred to Grace *“[e]xposing self (UNDRESSED)”*. In his evidence, he could not recall any further detail of what was said on that during his discussion with Mrs. X.

- 3.19 On 31st October, 2008, Mr. McGovern met with Ms D, the manager of Grace's day care centre, Day Service Provider A, in connection with his assessment of Grace. His notes of his consultation with her referred to a list of specific "*challenges*" concerning Grace, which included: "...*goes in and out of toilet undressed (at centre + in shops etc).*" He told the Commission that "*I suppose in terms of her participation on a day-to-day basis there were major issues around attention and around any kind of engagement with programmes and the sort of work she was assigned*".
- 3.20 Notwithstanding what was contained in Mr. McGovern's notes, Ms D said that she could not recall any incident at a shop where Grace went into or came out of it undressed. The Commission could not establish where this reference to shops originated.
- 3.21 Mr. McGovern did not recall having information regarding what Grace's history of undressing had been in Day Service Provider A; however, he became aware of this from reading documentation (much later) from the day centre which mentioned that Grace signalled her wish to have a bath by undressing.
- 3.22 Mr. McGovern told the Commission that Grace's behaviour of undressing in that way as a signal that she wanted to get into a bath "*absolutely*" did not surprise him as an experienced psychologist. As reported below, the fact that Grace "exposed" herself by her undressing behaviours was not a matter of concern of a sexual kind for Mr. McGovern. He described this behaviour as a form of communication or a cue and said that professionals working with people with severe or profound intellectual disability had to be sensitive to such cues in order to interpret their behaviour. Mr. McGovern described this as a non-verbal or gestural communication system. He observed that "*[i]t is a challenge and I think it may take a long period of time to establish from someone's routine and as I say from the consistency of their behaviour over time and what the triggers are in a situation because, again, you are using a sort of a signal system.*"
- 3.23 Mr. McGovern observed that staff workers would be very alert to such signals, whereas professionals like him would not. He said that he was, therefore, reliant on staff reports. He said that accumulated observation on the part of staff was of vital importance to the assessment.

- 3.24 In her evidence, Mrs. X said that Mr. McGovern told her about “*her behaviour with her pants*”, a reference to Grace’s stripping behaviours.
- 3.25 In his report to the HSE, which it received on 30th December, 2008, Mr. McGovern said that Grace “*engages in inappropriate sexual behaviour (she exposes herself). In regard to the latter, she may go in and out the adult training centre toilet in an undressed state...*”
- 3.26 However, in his evidence, Mr. McGovern made an important clarification with regard to that aspect of his report, telling the Commission that the fact that Grace exposed herself did not, in fact, automatically point to inappropriate sexual behaviour on her part. He said that what he was referencing there was a societal attitude that this was inappropriate behaviour. He said that people would not necessarily take into consideration that this was behaviour that was being displayed by someone with an intellectual disability. Mr. McGovern said that the view of it societally would be that it was inappropriate and sexual and that “*I suppose society gives a certain value judgment to some behaviour*”.
- 3.27 Mr. McGovern went on to say, “*So, it is challenging behaviour in another description, inappropriate, yes, socially unacceptable, yes. The sexual component can seem to be a bit of a misread, but it is still something which I suppose in terms of societal expectations and norms or standards, is tinged with a different kind of understanding than someone who [is] in-house and working in the field professionally*”. He added that “*the motivation isn’t sexual*”, but the outcome, in terms of what happened, would make it appear so. It was in this context, he said, that he used the language “*inappropriate sexual behaviour*” in his report.

Reference to “sexual frustration”

- 3.28 When Mrs. X was interviewed in 2012 by An Garda Síochána as part of its investigation into alleged abuse of Grace while in the care of Family X, she was asked about the bruises to Grace that were observed on 27th March, 2009 which led to the referral to the Sexual Assault and Treatment Unit (“SATU”) in Waterford Regional Hospital, as reported in detail at Section 5 below. In that interview, the following exchange was recorded:

“Q. In the days coming up to the day of the injury, was there any incident that would have led to the bruises?”

A. No, I can't remember. Maybe on the swings or in the bath, she used to bang herself. I found that [Grace] could be very sexually frustrated at times.”

3.29 In evidence to the Commission, Mrs. X was asked what she had meant by this statement and what it was that she trying to convey to the Gardaí. Pointing to her groin area, Mrs. X said that “...[Grace] *was always with her hand down there.*” Mrs. X said that Grace was always doing that, *“and scratching.”* Mrs. X’s evidence was that this was the conduct she witnessed which made her think that Grace was sexually frustrated. When she was asked why she thought that, Mrs. X said that: *“That was the only thing I thought of.”*

3.30 When she was asked from what age Grace was engaging in this behaviour, Mrs. X said (again gesturing towards the groin area):

“I can't remember what age but she used to go to the bath and when she would go to the bath she used to do the same, bang herself wicked with the face towel, she wouldn't stop.”

3.31 Mrs. X’s evidence was that this happened *“often”* when Grace went for a bath, but that it did not happen when she was being showered.

3.32 As will be seen in Part B, behaviour of this kind was also observed by staff in the residential unit after Grace moved there in July, 2009, and was cited as a concern regarding whether or not she might have been sexually abused. The significance or otherwise of these behaviours, and whether they were, in fact, indicative of sexual abuse having occurred is reported at Part B. In that regard, see the evidence of Dr. Syed at Section 10 and that of Dr. Caffrey at Section 12 of Part B below.

Whether new behaviours were exhibited in the period preceding Grace’s move in July, 2009

3.33 There was an issue in the evidence of Mr. Smith and Ms D as to whether a concern had arisen in 2009, before Grace’s move to a residential placement, about new

behaviours on her part. In a note prepared by Mr. Smith on 25th May, 2009, he set out that Ms D had told him that Grace had exhibited “*several new behaviours*” over the past few weeks. These were noted as Grace’s hitting staff on the head with her knuckles to communicate or seek attention, running out onto the main road, taking drinks from other service users at lunchtime, and refusing to get onto the bus and then banging her head on the ground. Mr. Smith made a note that “[a]ll *these are new behaviours with no apparent antecedent or cause*” and that Ms D was quite concerned about how the incidents would be managed. Mr. Smith’s note also recorded that Ms D wanted the input of a psychologist and asked that he address that with Ms Margaret Browne, the HSE’s Coordinator of Disability Services in Waterford Community Care.

- 3.34 In her evidence, Ms D agreed that she had discussed Grace’s behaviour in that regard with Mr. Smith. However, she did not agree that they were “*new*” behaviours. Ms D noted that, while there might have been an “*escalation at that time in behaviours*”, they were not new. She could not be certain if Grace had refused to get on the bus or if she had seen her bang her head prior to May, 2009. Her evidence was that Grace’s hitting staff on the head with her knuckles to communicate or to seek attention and her taking drinks from others was, in fact, a regular occurrence and that this type of behaviour continued at the time of her giving evidence at the Commission. It appears from the evidence that, while these behaviours of Grace may have become more intense around that time, they were not new. Ms D could not remember talking to Mr. Smith about this or about how these incidents were to be managed, but she recalled being quite concerned, because Day Service Provider A did not have the input of a psychologist.

4. Evidence with respect to Grace’s home life and living arrangements

- 4.1 Evidence with respect to Grace’s home life and living arrangements for the purposes of this Chapter includes evidence about her relationship with Mrs. X and Mr. X and with others in the household. Various aspects of Grace’s life and living arrangements are considered in the other chapters of this Volume, which should be read with this Chapter.
- 4.2 In considering the question as to whether there was evidence that established that Grace was subjected to sexual abuse, the Commission has examined the evidence

insofar as it concerned both her life and circumstances, and considered all matters relevant to the weight to be attached to that evidence.

- 4.3 As reported at paragraph 1.6 above, there was no direct evidence provided to the Commission in the course of its investigations that Grace had been subjected to sexual abuse by any person, named or unnamed, or by any particular member of the Family X household.

Mrs. X and her relationship with Grace

- 4.4 The Commission has reported upon the nature of the relationship between Mrs. X, as Grace's carer, throughout the chapters in this Volume, in the context of the separate issues with respect to Grace's care, considered in each chapter. Without detracting from the detail reported in those chapters and the issues of concern identified with regard to aspects of Grace's care, the observations as set out below can be made.
- 4.5 Mrs. X was Grace's carer from February, 1989, when Grace was placed with her as a foster child by the SEHB, until July, 2009 when Grace was removed from her care by the HSE. Grace lived with Family X from the age of 10 to the age of 30. Mrs. X was aged 53 when Grace was placed with her and was aged 73 when Grace was removed from her care.
- 4.6 Mrs. X was the person who attended to Grace's day-to-day needs, including her clothing, her sustenance, her sleeping arrangements⁴ and her personal care, including showering and bathing. She also managed the care needs that arose from Grace's incontinence. The standard of the care provided is considered and reported upon in Chapter 3 of this Volume.
- 4.7 There were occasions when Mrs. X was not at home for periods during the day and the evidence with regard to periods when she worked part time and about Mrs. X's daughter's involvement in caring for Grace on occasions when she lived in the house (Mrs. X's daughter died in 1995) is reported in Chapter 3 of this Volume. The Commission is satisfied, however, that the reality of the situation was that Grace was fully dependent on Mrs. X for her care. The evidence with respect to Grace's daily life

⁴ The evidence with respect to sleeping arrangements, considered below in more detail, established that Mrs. X and Grace generally slept in the same room.

over the years, reported in Chapter 6 of this Volume, established that Grace was generally in Mrs. X's company and in her charge.

- 4.8 The Commission found that Mrs. X had a matter-of-fact, practical and, at times, basic approach to addressing Grace's care needs. Mrs. X was conscious of the extent of Grace's difficulties caused by her intellectual disabilities and sometimes referred to or acknowledged these in a blunt fashion. However, this did not mean that Mrs. X did not also demonstrate care for Grace. It is undoubtedly the case, on the evidence, that she knew Grace better than anyone else, and was most familiar with Grace's likes and dislikes, mode of communication, and behaviour. Mrs. X did not have any expertise or training in managing the care of a person with profound intellectual disabilities on a full-time basis, and was largely left to her own devices by the SEHB and the HSE with regard to the management of Grace's care needs.
- 4.9 There was evidence that Grace looked to Mrs. X for comfort, and there was evidence of attachment between them and of Grace's reliance on Mrs. X. The evidence of this attachment is reported upon in Chapter 6 of this Volume and referred to below. In the course of her evidence, Mrs. X conveyed a sense of pride in how she had managed with Grace. Mrs. X's perspective, as conveyed in her evidence to the Commission, and in her engagement with officials of the SEHB/HSE over the years, was that she felt that Grace was well cared for by her and that she was happy at home.

Mrs. X's view of Grace's attachment to her

- 4.10 The evidence to the Commission of Mrs. X's relationship with Grace is considered in Chapter 6 of this Volume and is reported upon in the other chapters of this Volume in the context of other aspects of Grace's care. Grace's high level of dependence on Mrs. X is referenced throughout those chapters.
- 4.11 When she was asked at the Commission about what she believed Grace's attachment was to her, Mrs. X said that there was attachment "*in some things*", but that Grace would go to anyone. However, Mrs. X said that, "[w]ell I believed she loved all of us...Me, [and my late daughter], because [my daughter] looked after her seven years". The Commission is satisfied that the reference to her late daughter's looking after Grace for seven years was not an accurate statement, but was a reference to occasions on which she helped to mind Grace over the times that she lived with Family X.

- 4.12 When asked for the basis of that belief, Mrs. X attributed it to Grace's attitude and said that often *"she'd come and she'd sit on my knee and cuddle me, dead happy."* Mrs. X confirmed that when Grace was tired or upset she would come to her and look for comfort from her. Mrs. X also said that Grace always came to her if people were acting up on the bus or if somebody was getting at her. She described how Grace would take both of her (Mrs. X's) hands in hers and dance on the floor to try to tell her that there was something wrong. She explained that she *"would jump on her feet, she always did that"*. Mrs. X said that *"like any kid would go to their mother, they go for comfort, she used to come to me."*
- 4.13 Mrs. X was at times withdrawn, guarded and sometimes monosyllabic in her evidence and did not easily articulate or express her views on matters of this nature. However, at times in the course of her evidence to the Commission, she became upset and emotional when speaking about Grace.
- 4.14 There was no evidence from the Commission's investigations reported in this Chapter that established that Mrs. X had been involved in sexual abuse of Grace.

The issue of comments on Grace's appearance

- 4.15 It is appropriate at this point to address the evidence regarding a concern noted by Mr. Smith and Ms Eileen Griffin, Liaison Social Worker, about Mrs. X's comments on Grace's appearance on the occasion of their visit to Mrs. X and Grace at the home of Family X on 13th September, 2007.
- 4.16 Mr. Smith's and Ms Griffin's views on the occasion of their visit are reported upon in detail in Chapter 1 of Volume 1, which should be read in conjunction with this Chapter. Neither of them had ever met Mrs. X or Grace before this visit, which was the first time that anyone from the SEHB/HSE had visited the house since the SEHB's social worker, Ms Dianne Leyshon, visited in April, 2001 (reported in the Second Substantive Interim Report).⁵
- 4.17 With respect to one aspect of this visit, as reported, Mr. Smith considered that Mrs. X had made some *"unguarded statements"* in response to the questions put to her, instancing her comments on Grace's figure, which he said he thought were a *"totally*

⁵ The evidence with regard to visits to the placement by SEHB personnel before 2007 is reported in the First and Second Substantive Interim Reports.

bizarre thing” for a foster carer to say. These comments are referred to below. He saw this as Mrs. X’s *“drawing attention”* to Grace and as to whether she was *“attractive”* or not and *“drawing our eyes towards [Grace’s] body.”* Ms Griffin also believed that Mrs. X *“put [Grace] up on show a bit”* and said that it was quite uncomfortable.

- 4.18 In this regard, Mr. Smith’s note recorded that Mrs. X told Mr. Smith and Ms Griffin that Grace would soon be 29 years of age, adding that *“she thinks she’s 16 she’s got such a lovely figure, so slim”*. To an extent, this echoed the description of Grace’s figure, as referred to at various points in the First and Second Substantive Interim Reports. Mr. Smith noted that Mrs. X also directed his and Ms Griffin’s attention to the tan on Grace’s arms. Mrs. X had no recollection of this in her evidence.
- 4.19 Mrs. X, who had a very poor memory of the meeting, also did not remember mentioning Grace’s figure. She was not aware of how this was interpreted by Mr. Smith at the time.
- 4.20 Mr. Smith’s note recorded that Grace was *“very pleased to greet us”* and held out her arm to shake hands with them both. It said that she appeared to be *“smiling and excited.”* It also described Mrs. X as appearing to be *“very appropriate”* with her and stated that Grace stayed very close to Mrs. X throughout the visit.
- 4.21 Ms Griffin agreed with Mr. Smith’s description of the relationship between Mrs. X and Grace as *“appropriate”* and said that there appeared to be warmth between them. She recalled Grace’s *“holding [Mrs. X] quite a bit”* and described Mrs. X as *“very protective”*. She said that Mrs. X was *“brushing [Grace] a lot”* and that they *“kept close”*. Mrs. X confirmed in her evidence that Grace was accustomed to stay close to her. This was consistent with evidence the Commission heard about Grace’s closeness with Mrs. X and her dependence upon Mrs. X.
- 4.22 In her evidence to the Commission, as reported in the First Substantive Interim Report, Ms Helen Hawe, who was a Public Health Nurse, had also described Mrs. X as very protective of Grace.
- 4.23 In a later draft social work report which Mr. Smith prepared in January, 2008, he recorded: *“...I found some of Mrs. [X’s] own description of [Grace] as being rather odd. She remarked on how attractive [Grace’s] skin was, and added, ‘she thinks*

she's 16, she's got such a lovely figure, so slim'. I have to say this comment surprised me as [Grace] has no concept of her age or the ageing process, or how attractive she might be."

Finding

- 4.24 The Commission is not satisfied that Mrs. X's comments to Mr. Smith or Ms Griffin about Grace can be regarded as evidence that suggests any mistreatment of Grace, in particular with reference to the question of sexual abuse under consideration in this Chapter. The Commission is not satisfied that the nature of such comments or the circumstances in which they were made to Mr. Smith and Ms Griffin on their introduction to Grace were such that they should be viewed in that light. The Commission is satisfied that it would be unsafe to draw any such adverse inference.

Mr. X and his relationship with Grace

- 4.25 The extent of the evidence to the Commission of the type of relationship that existed between Mr. X and Grace was more limited, as reflected in the evidence reported throughout the chapters in this Volume.
- 4.26 Mr. X's involvement in opposing Grace's proposed removal by the SEHB from her placement with Family X in 1996, and the surrounding sequence of events, are reported in detail in the First Substantive Interim Report. His interactions with SEHB personnel on the very limited number of visits made by health board staff to the placement up to the year 2000 (when he passed away) are reported in the Second Substantive Interim Report.
- 4.27 Mr. X was 67 years of age when Grace came to live with Family X as a foster child on 22nd February, 1989. He died in June, 2000, aged 78, having suffered from Parkinson's disease and been ill for some time. The evidence with respect to his relationship with Grace tended to convey that his role in her care was limited and that this was attended to by Mrs. X.
- 4.28 There was no evidence from the Commission's investigations reported in this Chapter that established that Grace had been subjected to sexual abuse by Mr. X.

Grace's sleeping arrangements in the Family X placement

Preliminary

- 4.29 The question as to where Grace slept in the house was a matter that was queried by Mr. Smith on his visit to the placement with Ms Griffin in September, 2007. This is reported upon in Chapter 1 of Volume 1.
- 4.30 Before considering the evidence heard by the Commission regarding sleeping arrangements, these concerns of Mr. Smith on this matter are set out below.

Mr. Smith's concerns

- 4.31 Mr. Smith raised Grace's sleeping arrangements as a concern after he became involved in her case in 2007. Chapter 1 of Volume 1 reports upon the origin of his concerns, which were referable to his conversations with Mrs. Z and his first visit to Mrs. X's house on 13th September, 2007, when he concluded that the room shown to him by Mrs. X as the one where Grace slept was an inappropriate room for Grace, or that she slept somewhere else.
- 4.32 Mr. Smith's concern about what he described as Grace's unusual sleeping arrangements was repeated in reports and commentary on Grace's case in documentation examined by the Commission. For instance, referencing Grace's "*domestic arrangements*", including her "*sleeping arrangements*", Mr. Smith expressed a concern in his report in respect of Grace dated 11th November, 2009 that they "*appear to have been unconventional and she lived with three adult males as well as her former foster parents.*"
- 4.33 It was the account given to Mr. Smith by Mrs. Z of the sleeping arrangements in the house when her daughter (Z.Z.) stayed there in the late 1980s and early 1990s, together with Mr. Smith's concern about men living in the house, that caused him to raise an issue with respect to Grace's bedroom. Communications between Mr. Smith and Mrs. Z are reported upon in Volume 1 and repeated below for ease of reference.
- 4.34 Describing the sleeping arrangements in Family X's, Mr. Smith's note of his conversation with Mrs. Z stated that Mrs. Z had said that Mr. X did not sleep in the same bed as Mrs. X, but in a little room past the kitchen. The note stated that Mrs. Z told Mr. Smith that her daughter, Z.Z., slept in the same bed as Mrs. X. She told him

that she “*challenged*” Mrs. X on that at the time, and was told by her that it would help Z.Z. to settle.

- 4.35 Mrs. Z’s evidence to the Commission on the sleeping arrangements was that when Z.Z. went to the placement with Family X, her family had made a cot for her, which was the same size as a single bed. This was to prevent her falling out of bed during the night. This cot was placed on top of one of the single beds in the room where Z.Z. slept. According to Mrs. Z, Z.Z. slept upstairs in a bedroom where there were two beds, one of which was Grace’s. She said that Mrs. X’s room was “*across the way at the opposite side.*”
- 4.36 Mrs. Z said that Mrs. X “*occasionally*” slept in the same bed as Z.Z. and she said that she queried that with her and was told by Mrs. X that she did that occasionally to comfort her. Mrs. Z said that she told Mrs. X that that was not necessary at the time. Her evidence was that that was the information she had conveyed to Mr. Smith. She said in evidence that Z.Z. never slept with anyone at home and that there was no need for Mrs. X to sleep with her.
- 4.37 Mr. Smith also noted that Mrs. Z told him that there were other men living around Family X’s house.
- 4.38 It was suggested to Mr. Smith on Mrs. Z’s behalf that she would not have told him that Mrs. X and Z.Z. always slept in the same bed, only “*sometimes*”. Mr. Smith said that he “*heard it originally that [Z.Z.] would sleep in the same bed.*” He did not think that they had had “*any discussion about whether that was always the [sleeping] arrangement*”. It is evident that the precise position in this regard, as understood by Mrs. Z, was not clarified in their conversation.
- 4.39 Mr. Smith’s 2010 update to his 2008 report (reported on in Volume 1) noted that Grace was also resident in the placement at the time that Z.Z. was there. Mr. Smith went on to set out in that update report the sleeping arrangements as he understood them to have been described by Mrs. Z. In this regard, he set out his understanding that Z.Z. and Mrs. X shared a bed in Mrs. X’s bedroom and that Grace was in

another bed in that room.⁶ He noted that Mr. X slept in a room off the kitchen and that Mrs. X's daughter and her young son were in the downstairs bedroom.

4.40 Mrs. Z took issue with the reference to the statement that Z.Z. and Mrs. X shared a bed, stating that she would not have told Mr. Smith that Z.Z. always slept in the same bed as Mrs. X. Her evidence was that what she had been told by Mrs. X was that Z.Z. occasionally slept in the same bed as her in the circumstances set out previously. With respect to this aspect of this report, Mr. Smith said: *"Well she told me that that was the sleeping arrangement because actually, you know, we even did the sort of diagram on my handwritten notes [of his home visit to Mrs. Z in November, 2009], you know. So I don't think we had any discussion about whether that was always the arrangement..."* He went on to say that he did not discuss with Mrs. Z whether it was a constant arrangement.

4.41 It is evident that the position with regard to Z.Z.'s sleeping arrangements in Family X's, as understood by Mrs. Z, did not become clarified in the course of Mr. Smith's meeting with her in November, 2009.

Layout of the house

4.42 In 2019, the Commission conducted an inspection of the Family X house in the course of its investigations.

4.43 There were three bedrooms in the house, referred to as Bedroom 1, Bedroom 2, and Bedroom 3 for the purposes of this report. There were two bedrooms upstairs, Bedroom 1 (to the right) and Bedroom 2 (to the left), and the downstairs sitting room was used as a bedroom at night, Bedroom 3.

Sleeping arrangements in house

4.44 It was suggested by Alpha, Mrs. X's grandson, in evidence that Mrs. X converted the sitting room into Bedroom 3 for her and Grace to sleep in. He could not be clear as to when this occurred, since he was eight months old when Grace came to the house. Mrs. X's evidence was that Bedroom 3 was a sitting room turned bedroom and, as such, it had always been a bedroom. She could not remember at the time of giving

⁶ Mrs. Z told the Commission that that was inconsistent with her earlier evidence to it regarding what she said she had told Mr. Smith.

her evidence who used it prior to Grace's arrival. Consequently, the year this conversion occurred has not been established.

- 4.45 According to Mrs. X, before Grace arrived in February 1989, she slept upstairs in Bedroom 1 with Mr. X. She said that, when Grace arrived, she and Grace slept downstairs in Bedroom 3. Mrs. X, however, later changed that evidence by confirming that she slept upstairs with Grace in Bedroom 1 after Grace's arrival and then, some time afterwards, moved downstairs. According to Mrs. X's evidence, it was only she and Grace who slept in Bedroom 1. Mrs. X said that Bedroom 1 had two single beds. At an earlier stage in her evidence, Mrs. X described Bedroom 1 as divided by way of a "*middle thing*" in the room as a partition.
- 4.46 Gamma, who was Mrs. X's nephew, thought that Mr. X was always in Bedroom 1. Alpha recalled that Mr. X was the sole occupant of that room. Alpha and his mother slept in Bedroom 2. Alpha confirmed that Bedroom 2 remained his bedroom at the time that he gave evidence. Bedroom 2 had always been his bedroom, he said. Mrs. X also said this at the Commission.
- 4.47 Gamma thought that Mrs. X slept in Bedroom 3 with Grace. He did not know when this commenced and could not say what the sleeping arrangements were within the house in the early years. He recalled that, at the time of Mr. X's death (June, 2000), Mrs. X slept in Bedroom 3 with Grace. He did not know how Bedroom 3 was furnished when Mrs. X and Grace slept there. He said that he was never in there, but he presumed that there were beds.
- 4.48 Alpha told the Commission that Mrs. X always remained downstairs and continued to sleep downstairs in Bedroom 3 at the time that he gave evidence to the Commission.
- 4.49 Alpha went in and out of Bedroom 3 when he was younger. He thought that it had two single beds or a double bed and a single bed. According to his recollection, there were certainly two beds in there. Mrs. X's evidence was that, in Bedroom 3, Grace had a single bed and she (Mrs. X) had a bed that opened out - a chair bed. In her earlier evidence to the Commission, Mrs. X said that she and Grace would share a bed in Bedroom 3 and that there were two other beds. She said that when the children came for the Holiday Placement Scheme, she (Mrs. X) and Grace stayed downstairs in Bedroom 3.

- 4.50 Speaking of the position in or around 2007, Mrs. X said that her bedroom was downstairs in Bedroom 3 and that Grace was with her. Mrs. X said that when the “other” children came, there were three beds in Bedroom 3. However, she said that when the children stopped coming, she changed it and ever since there was one bed and one fold-out bed in the room. This was the room where Mrs. X continued to sleep, as was evident from the Commission’s inspection of the property.
- 4.51 The evidence was that, over the years, Mr. X slept in either Bedroom 1 upstairs or in the little conservatory extension to the front in order to be beside the bathroom. There was some evidence to suggest that he used Bedroom 3 during the day.
- 4.52 Gamma initially said that, from what he could remember, Mr. X always slept upstairs. Later in his evidence, he recalled that Mr. X had slept downstairs for a time when he became ill because he needed access to the bathroom. He thought this was for about 12 months. Gamma was of the view that, when Mr. X moved downstairs to be nearer to the bathroom, he slept in the conservatory room. This corresponded with Mrs. X’s evidence that Mr. X never slept in Bedroom 3, even when he became ill. She said that he sat in the front room and that he never moved. However, later in evidence, she recalled that once Mr. X became ill, he put a single bed in a downstairs room as he could not walk up the steps. This was the room beside the toilet so that he could walk to it.
- 4.53 Grace moved in with Family X in February, 1989. The Holiday Placement Scheme was in operation from 1984 to 1990 and ran throughout the months of July and August only. A maximum of two children were placed by the Brothers of Charity at any one time and children would stay for either a week or two weeks. However, as noted in the SEHB Investigation Volume, the Brothers of Charity had raised concerns that there were other children staying on a private basis during the Holiday Placement Scheme, when Mr. and Mrs. X had assured them that that would not be the case.
- 4.54 The Commission also had evidence from Mrs. Q whose daughter, Q.Q., stayed with Family X over the years from 1992 up until 2013. She recalled that Q.Q. stayed in a little room downstairs, just off the kitchen, which contained two single beds and a sofa bed. Mrs. Q said that Mrs. X always slept in the room with her because Q.Q. had epilepsy and if she had a seizure at night, she needed to have somebody to hand. She thought that Grace slept there too.

- 4.55 After Mr. X died in mid-2000, Gamma moved into Bedroom 1 in the main house.
- 4.56 Alpha recalled Gamma's coming to live in the house shortly after Mr. X died. He said that Gamma moved into what was his late grandfather's room upstairs. Alpha said that, during his time in secondary school, Gamma slept in Bedroom 1 and that this remained his room at the time that Alpha gave evidence to the Commission. Mrs. X and Grace were, he said, downstairs in Bedroom 3.
- 4.57 Beta, who lived in an outbuilding on Family X's property, said that he did not know where anybody's bedroom was in Mrs. X's house. He had only ever been upstairs to sweep the stairs for Mrs. X. While he tried to assist with his recall, his evidence was quite confused. Ultimately, he was not able to assist as to where Grace slept in the house.

Knowledge of Grace's sleeping arrangements

- 4.58 The evidence that emerged with respect to the SEHB/HSE's knowledge of Grace's sleeping arrangements was scant. There were no references at all in the records and documentation of the SEHB/HSE disclosed to the Commission concerning where Grace was to sleep or as to whether she shared a bedroom with anyone in the house prior to August, 2007, when Mr. Smith raised this on his visit to the house. This applied to the records covering the period of Grace's placement in the house as a foster child and thereafter for the time that she remained with Family X as a vulnerable adult.
- 4.59 The Commission did not have the evidence of Ms Greaney, the health board's Children's Officer who visited the household when Grace was a foster child. She was deceased at the time of the establishment of the Commission. The nature and extent of her visits to the household have been reported in the First Substantive Interim Report. The only evidence that the Commission had on the question of her knowledge of Grace's sleeping arrangements was Mrs. X's evidence to the effect that Ms Greaney knew the house and also where everyone was sleeping. It was not possible to test this evidence or as to what, if anything, was conveyed to Ms Greaney by Mrs. X on this topic.
- 4.60 In her evidence, Ms Frances Jones, SEHB Social Worker, who visited the house on one occasion on 20th January, 1999, told the Commission that she recalled that

Grace had her own bed and that she had no concerns about her sleeping arrangements. This was the only evidence that the Commission received from a SEHB/HSE employee or official before the year 2007 on the question of sleeping arrangements. Ms Jones' short involvement in Grace's case has already been reported in the Second Substantive Interim Report.

- 4.61 As regards the personnel from Day Service Provider A, in describing Grace's sleeping arrangements in his report on Grace dated 27th November, 2000, Mr. M set out that:

"[Grace] goes to bed between 20.00 – 20.30 hrs each evening, and will fall asleep in about 10 minutes. She sleeps in her own room and is an excellent sleeper. [Grace] rises on weekday mornings at around 7 a.m. There are no great problems in getting [Grace] to rise, one call from the kitchen and she is up immediately. [Grace] needs assistance when washing hands/face etc."

- 4.62 This report, and the circumstances in which it was prepared, have been reported in the Commission's Second Substantive Interim Report. The above information, provided by Mrs. X, tended to convey that Grace had a bedroom to herself at that stage. However, the Commission is satisfied that this was not correct and that Grace slept in the same room as Mrs. X at this time.

Findings with respect to Grace's sleeping arrangements

- 4.63 On the evidence with regard to Grace's sleeping arrangements, the Commission considers that, in all likelihood, for a substantial part of Grace's first 10 years in Family X's house, she slept in Bedroom 1 upstairs with Mr. X and Mrs. X. The Commission accepts the evidence that there was more than one bed in that room, although it was not possible clearly to establish whether this was always the case or whether or not Grace sometimes slept in the same bed as Mrs. X and Mr. X. At some point, which cannot be precisely established from the evidence, Mrs. X moved downstairs to Bedroom 3 (the front room that also served as a bedroom) and shared that room with Grace. It is likely that Grace and Mrs. X mostly slept separately in this room, but they may sometimes have shared the same bed. The Commission is satisfied that there was a period of time during which Mr. X continued to sleep in Bedroom 1 upstairs, but from sometime around 1998/1999, as he became more

unwell, he slept in an area near the kitchen downstairs, adjacent to the toilet. The second bedroom upstairs (Bedroom 2) was always Alpha's room, which he initially shared with his mother and afterwards had to himself.

- 4.64 Over the time that Z.Z. stayed with Family X, it appears from the evidence that she also slept upstairs in the room where Grace slept. In later years, it is likely that Q.Q. slept downstairs with Grace and Mrs. X on the occasions when she stayed in the house. The Commission is satisfied that, in all likelihood, other children on holiday or on private placements from time to time shared the room in which Grace was sleeping, either upstairs or downstairs.
- 4.65 Considering Grace's sleeping arrangements in the context of considering whether the evidence established that she was subjected to sexual abuse, it must be observed that the fact that she did not have her own bedroom was not a matter that should, of itself, necessarily give rise to a concern that she was subjected to sexual abuse. The modest size of the house and the number of bedrooms, the number of residents, and the number of persons who stayed there on placement from time to time, together with the high level of Grace's dependency on Mrs. X for her care, were possible factors that influenced Grace's sleeping arrangements in the household.
- 4.66 What can be stated is that the extent of Grace's vulnerability, having regard to her level of intellectual disability, her inability to communicate, and her high level of dependence on others (as extensively set out in the Commission's report), was an important factor to be taken into account when considering risk factors associated with her living circumstances. In this regard, the Commission considers that the sharing of a bedroom with Mrs. X and Mr. X together, over the period of time that this occurred, was in fact a highly unsuitable arrangement for a foster child, irrespective of whether or not such a child had Grace's vulnerabilities. The Commission is satisfied that any proper assessment of such an arrangement would have identified this as an arrangement that was not sufficiently protective of Grace as a highly vulnerable individual and that this was a risk factor for abuse in all the circumstances. Nonetheless, there was no evidence to the Commission that Grace was subjected to sexual abuse in that setting.
- 4.67 The Commission is satisfied that, prior to 2007, Grace's sleeping arrangements were not properly considered or inspected by the SEHB/HSE over the time that she lived with Family X. That this was the case, in the context of the care of a foster child with

Grace's vulnerabilities and thereafter as a vulnerable adult, was particularly remarkable and a fundamental failing on the part of the SEHB/HSE in their duty to Grace in the overall management of her case. There was no evidence of any kind provided to the Commission that the nature of Grace's sleeping arrangements was ever raised as an issue with Mrs. X or Mr. X, until raised by Mr. Smith with Mrs. X arising from his visit to the house in September, 2007. The Commission is satisfied that this was an appropriate matter for Mr. Smith to have enquired into on his becoming involved in Grace's case.

4.68 The Commission is also satisfied that when Grace was placed into foster care, there was no stipulation that she should have her own separate bedroom in the house. The Commission finds that the SEHB and the HSE left the nature of Grace's sleeping arrangements to Mrs. X and Mr. X to determine.

4.69 It is worthy of particular note that the question of where Grace slept in the house did not even receive attention in the year 1996, when it was ultimately decided by officials of the SEHB to leave her in the Family X placement notwithstanding the allegation which was conveyed to the SEHB in March, 1996 with respect to another service user, E.E., referred to above. The significant failings in the management of Grace's case following the making of that allegation, and in 1993, when the SEHB's Senior Social Worker investigated concerns relating to Z.Z.'s presence at the Family X placement, are reported in the SEHB Investigation Volume and the First Substantive Interim Report respectively.

Men connected to the Family X household

Introduction

4.70 The Commission examined two separate accounts with respect to men and Family X. The first refers to men living in structures outside Family X's house and the second to a suggestion that men were frequenting Family X's house.

4.71 The reference to two males who lived in structures outside the house was initially recorded in a note written in 1996. On 26th September, 1996, Dr. Walsh, SEHB Senior Area Medical Officer, had a conversation with Ms O'Sullivan, SEHB Public Health Nurse, and took a note of some information that she understood had been obtained by Ms O'Sullivan who, in turn, had obtained this from the Local Public

Health Nurse in the area where Grace lived. Dr. Walsh's note set out the following points:

"(1) [Beta] (30 – 40) from U.K. Helps [name of Beta's employer] – no relation to [Xs]. In caravan at back of [Xs] – always in house (2) [name] (nephew of Mrs [X]) also lives in caravan. Always in house. Used help [details of Beta's job]. [Named person] looks after children because Mrs [X] works –[in a local shop] and somewhere else. [Name of doctor] met Mrs [X] in a house where she was working."

- 4.72 Ms O'Sullivan said that she must have contacted the Local Public Health Nurse looking for background information about Grace and that, when she received the information, she passed it on to Dr. Walsh. Ms O'Sullivan said that she never saw a caravan at the back of Family X's house and that she never saw anyone else in the house. The particular Local Public Health Nurse had retired by September, 1996 and had no recollection of having this conversation with Ms O'Sullivan.
- 4.73 The evidence to the Commission with respect to the times when Mrs. X did work outside the house is reported in Chapter 3 of this Volume. The evidence with respect to Gamma's and Beta's involvement in the household, and their limited involvement with Grace, is reported below.
- 4.74 What appears to have been a second suggestion that there were male visitors who visited the Family X household, was a matter that was mentioned in a memorandum of Ms Marie Kennedy, then Child Care Development Officer, to Mr. John Magner, Acting / Programme Manager, Community Care dated 25th April, 1996. In that memorandum, she stated that *"[t]here seems to be a lot of male visitors to the house"*. Ms Kennedy was unable to elaborate on this remark when giving evidence to the Commission. However, she said that she must have learnt it at a meeting on 23rd April, 1996. The official minutes of that meeting contained no record of that information. This matter is fully reported in the First Substantive Interim Report.
- 4.75 The references to men in or visiting the Family X household in the above context was accompanied by the suggestion or concern, certainly from 2007, when Mr. Smith became involved in Grace's case, that this was a worrying feature, in particular in the context of any question as to whether Grace may have been subjected to sexual abuse.

- 4.76 It is appropriate to report on Mr. Smith's concerns before reporting on the circumstances of the male individuals (other than Mr. X) who were part of the Family X household. It is important to reiterate, at the outset, that there were no allegations of abuse of Grace of any kind made by any person or body to the Commission, about any of these male individuals, whether as a member of the household or as a visitor.

The concerns of Mr. Smith

- 4.77 The background to Mr. Smith's concern about men in connection with the Family X placement arose from a number of matters, namely the reference in the file to men living in outhouses, his conversation with Mr. M about a man banging on the window of the Day Service Provider A bus, and the fact that Mrs. Z had told him that there were other men living around Family X's house. These matters have been reported on in Volume 1 of the Commission's Final Substantive Report, which should be read in tandem with this Chapter.
- 4.78 Mr. Smith told the Commission that there "*seemed to be lots of different men being able to come and go*", coupled with "*limited toileting facilities*", and that he considered this suspicious. Mr. Smith believed that Grace would have to share those facilities with these men and said that he had also read in Grace's file that there were men living in outbuildings. The concern as to whether there were men "*being able to come and go*" was somewhat conflated with Mr. Smith's concern, at that stage, about men living on the property or sharing facilities with Grace.

Home visit on 13th September, 2007

- 4.79 Mr. Smith said that Mrs. X told him that her nephew, Gamma, was the only person living at the house, in addition to her grandson Alpha and Grace. He said that Mrs. X told him that Gamma lived in one of the outhouses at the back of the house. In his note, Mr. Smith recorded that he noticed another shed/cottage similar to Gamma's, and that this also had curtains and looked like it could be lived in. Mr. Smith noted that Mrs. X said that this was just somewhere to put her bike, something Mrs. X disputed at the Commission. Mr. Smith told the Commission that "[he] *didn't really get the sense that [they] were getting the full information about who was actually there at the house.*" He said that "*it didn't really feel right. It didn't feel convincing what she was saying about who was out at the house.*" In this regard, the Commission notes Gamma's evidence to the effect that he moved into the main house following the

death of Mr. X in June, 2000. In his subsequent report of 10th January, 2008, Mr. Smith noted that he was “*struck by the unusual outbuildings*”.

- 4.80 The Commission is satisfied from its investigations that at the time of this visit in September, 2007, Beta also lived in an outbuilding at the property. There was also evidence that Q.Q. stayed in the house during the week Monday to Friday, and only returned to her family for weekends. The Commission is, therefore, satisfied that Mr. Smith was not given full information about who was living on the property at the time of this visit.
- 4.81 The Commission is satisfied from its investigations that there were four male residents of the property over the time that Grace lived with Family X. Three of these males were members of Family X. These were Mr. X (who died in 2000), Alpha, who was Mrs. X’s grandson, and Gamma, Mrs. X’s nephew. The fourth man was Beta, who worked and continues to work locally and who had lived in an outbuilding at the rear of the property for many years at that stage.
- 4.82 The section entitled “The House and Surroundings” within Chapter 3 of this Volume, which describes the layout of the house and surrounds, should be read with this Chapter.
- 4.83 Mr. Smith’s summation in his report of 10th January, 2008 with respect to the above home visit in 2007 was as follows:

“There is no evidence that these men pose a sexual danger to [Grace], but it is certainly an unusual feature for a young woman in care to be sharing her home in this way. It should be noted that these men have probably been living with Mrs [X] for many years, and that indeed one file note suggests that Mrs [X] had a job and [Grace] would be cared for at home by [Gamma] when she was at work.”

- 4.84 Mr. Smith made reference to the configuration of Grace’s household in the course of the management of her case, as reported in Part 1 of Volume 1. Grace’s domestic arrangements and sleeping arrangements and the fact that “*she lived with three adult males as well as her former foster parents*” was also commented upon as a concern in Mr. Smith’s updated report on Grace of 11th November, 2009, postdating her removal from Mrs. X’s care. The Commission is satisfied that Mr. Smith, in his role as

social worker, was focused on Grace's best interests in gathering information on her domestic and sleeping arrangements at this time.

4.85 In his evidence, Mr. Smith said that he thought that the “*whole situation*” was very “*suspicious of sexual exploitation*”. He said that he was hearing that there were people coming up to the house and that he did not know what business they had there. Mr. Smith said that he was suspicious that “*this was some sort of set up in which disabled children, who lacked the capacity to make verbal disclosures or weren’t capable of being witnesses in court could be sexually abused.*” He said that this was the “*worst case scenario*” and that it was his role as a social worker to hypothesise at times in terms of the different possible scenarios. Mr. Smith said that despite his suspicions, he had approached his visit to the placement in September, 2007 with an open mind.

4.86 With respect to his draft social work reports in January and March, 2008, Mr. Smith said that his conclusion in the reports that Grace should be moved, was due to the inappropriateness of the placement and his concerns about Grace’s vulnerability to abuse, not that she had actually suffered abuse. In this regard, he explained that:

“It was that not only was this an inappropriate placement, but [Grace] was particularly vulnerable to abuse. So I mean I do make clear in the report, I’m trying to write a very conservative report that isn’t a shrill report and, in so doing, I’m being conservative in terms of what the actual evidence was of abuse. I’m not trying to make any kind of particular jumps to say that, you know, we clearly see that [Grace] is being abused or something like that. I was really staying as close as I could to what I’d observed and the amount of information to which I had access at the time.”

4.87 In the course of his evidence, Mr. Smith explained his thinking as follows:

“I suppose the way I think of it as a social worker...would be that if it were to come to light at a subsequent date that [Grace] had been sexually abused in some sort of a way, you know, would a reasonable person say that we have failed to protect her, right. So and that would be then a combination of saying, ‘well, you left her out in this placement with all of these men, she was staying in a downstairs

bedroom whilst her carer was upstairs in her bedroom.’ There were concerns about the carer indeed herself. There were a number of these concerns. This placement wasn’t properly regulated. These carers had effectively always been in control of [Grace’s] situation over the attempts by the health board to [wrest] control back from them. So I think a reasonable person would conclude that we had left [Grace] open to abuse.”

- 4.88 With regard to the above, it should be noted that the Commission did not have evidence that Grace slept downstairs while Mrs. X slept upstairs. The evidence indicated that they slept in the same room.⁷
- 4.89 Mr. Smith observed that, if Grace had not been so vulnerable, it would not have been as alarming a situation and he concluded therefore that, on balance, it was Grace’s vulnerability that was the main factor in his mind. However, he went on to say that Grace’s vulnerability was not the predominant factor because he did not draw a distinction between the two in that way, stating “...*within such an alarming situation. It was the whole situation I would say was repellent or repugnant to have such a vulnerable young woman living in this circumstance.*”
- 4.90 The gravamen of Mr. Smith’s report was therefore twofold: the inappropriateness of the placement based on his concerns, including those set out above, and the fact of what he considered to be Grace’s vulnerability to abuse. These matters have been considered in the context of the management of Grace’s case from 2007 to July, 2009, as reported in Volume 1.

Question of “different men being able to come and go”

- 4.91 With respect to Mr. Smith’s concern referred to above that there were “*different men being able to come and go*” to and from the household (other than the men who lived on the property), no evidence emerged in the course of the Commission’s investigations into Grace’s care that this was something that occurred. Indeed, no person or body advanced evidence to this effect to the Commission in the course of its investigations.

⁷ As reported in Chapter 1 of Volume 1, Mr. Smith had been told by Mrs. X that Grace slept in the downstairs bedroom during his home visit on 13th September, 2007.

4.92 The evidence that the Commission heard of male visitors to the household when Grace lived there related to neighbours who dropped in or Mrs. X's family members who visited on holidays in the summer. The Commission did not receive any evidence of male visitors coming to the house in circumstances that could be considered troubling or sinister insofar as Grace's position in the household was concerned. The comment by Ms Kennedy that there "*seems to be a lot of male visitors to the house*" was an isolated observation that appeared in the SEHB records for 1996 disclosed to the Commission. Ms Kennedy was not in a position to expand on this comment in her evidence to the Commission. This comment was not repeated, nor was it revisited at any stage, until Mr. Smith read this on Grace's file in 2007, giving rise to his concerns as to what this implied.

Male members of the household

4.93 In reporting on this aspect, the position of each male in the household, how they came to live there, the nature of their domestic arrangements, and their relationship with or level of day-to-day contact with Grace, as it emerged in the evidence provided to the Commission, are considered below. As is apparent, their accounts of Grace were not uniform, but were, instead, based on their individual memories of her in the household, bearing in mind their varying levels of familiarity or contact with her.

4.94 Evidence with respect to these persons has also been reported in the other chapters of this Volume when reporting on day-to-day life and other aspects of Grace's care.

Alpha

4.95 The Commission reports on Alpha's position in the household and his evidence with respect to Grace's care in Chapters 3 and 6 of this Volume. Aspects of his role in the household and, in particular, his involvement with Grace, are referred to below.

4.96 Alpha is the grandson of Mrs. X, the son of her late daughter. He is 11 years younger than Grace. He grew up in the house and was reared by Mrs. and Mr. X following the death of his mother. The house is his home and at the time of his engagement with the Commission he continued to live there, while working in the locality.

4.97 Alpha grew up with Grace and when he was younger he considered her to be his sister. This was not something that he was told, but rather it was his impression of

Grace's place in the household. According to him, they were family. Prior to his going to school, they were together every day. Alpha had his own life growing up, with all of the features of school and outdoor life with friends and neighbours. He had a particular interest in horses, for which there was an excellent facility close by. His account of daily life as he recalled it was given in an open and informative manner.

Alpha's account on aspects of daily life and relationship to Grace

- 4.98 Alpha told the Commission that, from a very young age, he remembered children and adults with intellectual disabilities staying in the house. He was only eight months old when Grace came to live with Family X and parts of his evidence were based on early childhood memories. He had no involvement in Grace's care. He said that, when he was younger, he did not really have an understanding of her difficulties. He said that he knew that she could not talk and that that was the extent of his understanding when he was young. He recalled Grace as always smiling.
- 4.99 Alpha described both grandparents as "*the best in the world*" to him and said that he could not have asked for better. He said that he was reared by Mrs. X and that she took care of Grace and himself together. From his perspective, Alpha considered that his home was a "*very happy house*".
- 4.100 Alpha went to the local national school, which was a short walk from the house. Depending on the morning and on the weather, Mr. X walked him or Gamma dropped him to school. Mrs. X, along with Grace, sometimes walked him to school. After school, somebody would collect him but, as he got to fifth and sixth class, he walked home by himself. As a young boy, Alpha said that he was always collected and dropped off. He said that he was gone from the house during school hours and that, after school, he came home for his dinner. As he was very interested in horses, in the evenings he went out with his neighbours who had horses.
- 4.101 Alpha recalled that Grace liked going for Chinese and Indian meals and he told the Commission that he also went with the family to these when he was free. The family also did the shopping on these outings. At the weekends, however, Alpha would generally go to the neighbours to help with their horses.
- 4.102 Alpha said that he never saw Grace being boisterous or anything out of the ordinary when she was at a restaurant or when she was out of the home. He said that Mrs. X

had no problem controlling Grace when they were out and recalled that his grandmother would say “[Grace] *stop*” in a firm tone and that that worked with her.

4.103 As far as Alpha was concerned, his house was like any normal household. They had swings and, when he was a boy, he used to try to teach Grace how to play basketball. He said that this was difficult and that he was not successful. The Commission also heard evidence of this on Ms Leyshon’s visit to the household, as reported in the Second Substantive Interim Report.

4.104 Alpha recalled Grace’s attachment to her keys and how she could never be parted from them. She got agitated if they were mislaid or if somebody took them from her. He recalled that Grace made a noise or a kind of signal to say that her keys were not with her and that he knew immediately what it meant. He said that Grace would sit down and play with the keys and watch television and that this was all she ever really did. In his evidence, Gamma said that Alpha and Grace had a little game between them. Alpha would take the keys off Grace and she took them back off him. Gamma said that Grace did not want to play with anyone and that she was happy on her own.

4.105 When he was asked about the evidence given by Mrs. X to the effect that, on occasion, Grace would be given to suddenly screaming without any notice or indication that anything had caused it, and as to whether he remembered incidents like that, Alpha said that “[t]o be honest with you I don’t. I don’t know how you would say it, she did at times but it was just if she mislaid her keys, that kind of a thing.”

4.106 Alpha also said that he did not recall occasions described by Mrs. X when Grace would bang her head on the walls or floor for no apparent reason.

4.107 This evidence of Mrs. X with respect to Grace’s behaviours at home is considered further at paragraph 3.16 *et seq.* of Chapter 2 of this Volume. As noted in that Chapter, Mrs. X’s evidence as to the frequency of Grace’s behaviour of head banging, to the effect that this occurred “*all of the time*”, was not consistent with Mrs. X’s other evidence as to how Grace was at home (that she was “*no trouble*”) or with the evidence of other household members. The Commission is satisfied that this description by Mrs. X of the frequency of Grace’s behaviour in this regard was an overstatement or exaggeration by her at this point in her evidence. The Commission is not satisfied that this was a constant activity, but rather that Grace would engage in such behaviour if she got excited, or if something was bothering her, or if she was

annoyed or unhappy or someone took her keys. In this regard, Mrs. X described how Grace would go to the wall and bang her head against it, or hit her head off the table. The substance of Mrs. X's evidence, taken with that provided by Day Service Provider A personnel, tended to suggest that Grace's head banging varied from time to time, in terms of its intensity and force, between banging to tapping.

- 4.108 Alpha had memories of Grace's "*washing up*", recalling that he would have to rewash whatever she had washed. He had no recollection of her having any interest in dolls, teddy bears, or Lego, but he remembered that she had a great fondness for the swings.
- 4.109 Alpha continued to live at home after he finished secondary school. He was gone to work by half past five / half past six some mornings and returned home at about eight or nine o'clock at night. After he started working, his opportunity to see Grace was much reduced.
- 4.110 Alpha recalled that Beta and Gamma worked long hours. He said that, depending on the time of the year, Beta worked from seven or eight o'clock in the morning until nine or ten o'clock at night. Alpha very rarely saw him. He said that Beta had a keen interest in soccer and that he was always gone to field days, GAA matches and soccer matches.
- 4.111 There was no evidence of any kind provided to the Commission in the course of its investigations into Grace's care that implicated Alpha with respect to the concern that sexual abuse of Grace had occurred when she was residing with Family X.
- 4.112 In response to the Commission's inquiries concerning whether he had ever been involved in abuse, including sexual abuse, of Grace, Alpha was adamant in refuting any such hypothesis. There was no evidence of any kind to the Commission to the contrary.

Findings on Alpha

- 4.113 There was no evidence which indicated that Alpha was anything other than a positive or neutral feature of Grace's life in her placement. The Commission had no evidence that Alpha, as a male in the household, should have been a cause for any concern with respect to Grace's safety or well-being, having regard to the evidence provided

to the Commission in its investigations of Grace's care, and there was no allegation or evidence to the Commission that he had ever abused or mistreated Grace in any manner.

- 4.114 The Commission considered Alpha's evidence to be a reliable reflection of life in the household as he perceived it and of his impressions of Grace's day-to-day life when he was there. He was straightforward and helpful in giving his evidence to the Commission.

Gamma

Preliminary

- 4.115 The Commission has reported on Gamma's position in the household and his evidence with respect to Grace's care in Chapters 3 and 6 of this Volume, which should be read here. Aspects of Gamma's role in the household and his involvement with Grace's life are referred to below.
- 4.116 Gamma is Mrs. X's nephew. Gamma's father, Mrs. X's brother, lived with his wife and children in the house in which Mrs. X grew up. Gamma also grew up there. He was born in 1960. His parents are deceased. He had a number of siblings, some of whom emigrated.
- 4.117 Gamma moved into an outbuilding at the back of Family X's house in the mid-1980s. This situation arose because his family home became crowded. Mrs. X told him that there was a room in an outbuilding at the back of her home and offered it to him so that he would have a place to sleep. At first, Gamma did not avail of it, but he subsequently changed his mind. He did not intend to stay there long term, and was only supposed to stay a fortnight. When he moved into the outbuilding, Gamma recalled that there was only a felt roof on it, so he put on a zinc roof. The building contained one room, and consisted of cement blocks and plaster on the inside and outside. Initially, there were steel windows but, over time, Gamma put in teak windows. He also installed a hand basin and a stove. There was an outside toilet at the end of the garden. In 2000, after Mr. X died, Gamma moved in to live in the main house.

- 4.118 Gamma gave evidence of doing a number of small building jobs at Mrs. and Mr. X's house over the years. He constructed a conservatory-type room onto Family X's main house. Initially, Gamma put up the slab of concrete and Mr. X used to sit there on a nice day. However, when Mr. X got Parkinson's disease and winter came, Mr. X could not sit out because it was too cold. Consequently, Gamma added a roof and windows. Gamma told the Commission that he built it for Mr. X because he used to love to read the paper there and he thought it was a nice place for him. Gamma also built the garden shed where lawnmowers and garden equipment were kept. During the course of the inspection of the property by the Commission, Gamma pointed out that the tractor and timber on the land next to Mrs. X's property were his.
- 4.119 The base of a second outbuilding at the back of Family X's house was there when Gamma moved in. He added to it for Mr. X and it was used for growing plants. Gamma described how he put timber around it and made a frame and then a roof and added to it over time. Beta subsequently moved into this second structure. Beta's position is considered further below.
- 4.120 Gamma did not pay rent to his aunt, Mrs. X, for staying in the outbuilding. He told the Commission that he cut the grass and hedges and split the wood, and that she never questioned rent or money. Gamma continues to do odd jobs around the property. He would also drive Mrs. X if she wanted to go anywhere.

Gamma's account on aspects of daily life and relationship to Grace

- 4.121 Gamma described how he started work at eight o'clock in the morning and returned home at around seven or eight o'clock at night. His days varied, depending on what was going on. On returning home, he would call into the house to see if Mrs. X needed any blocks or coal or if she wanted anything done in the house. Gamma worked six days a week. He had Sundays off, though he worked the occasional Sunday. When he was off work on a Sunday, he did his own work, cutting wood and other things. Gamma had a meal with Mr. and Mrs. X on a Sunday evening.
- 4.122 During the years that he was living in the outbuilding, Gamma said that he did not go into the house in the morning. He said that he got up and got ready for work and had a cup of coffee. Gamma said that he washed using his hand basin in the toilet down at the end of the garden. He said that Mrs. X told him to use the shower and the bath whenever he wanted to.

- 4.123 After the death of Mr. X in 2000, Gamma was more closely involved in the house. He drove Mrs. X where she needed to go. On Sundays, they would go to a nearby provincial town and sometimes they would have a Chinese meal and Grace would be taken on these trips. They did the shopping afterwards. Gamma started those trips after Mr. X fell ill. Before Mr. X became unwell, Gamma sometimes took Mrs. X places with Grace if Mr. X was not available.
- 4.124 Gamma recalled that Mrs. X had friends that came and went from time to time. His impression was that Grace did not take any notice of them. Gamma said that Mrs. X had friends all over the place. He said that she was very well liked and that people called in for a cup of tea and a chat. According to Gamma, when relatives came from England to see Mrs. X, they stayed in a local bed and breakfast establishment and they called to visit her during the day.
- 4.125 Gamma did not recall when Grace first came to live with Family X; he just remembered her being there. He explained that he knew Grace because she was *“one of their own”* but he did not know all of the other children that came to stay with Family X.
- 4.126 Gamma said that Grace did not seem to do much, she only sat in the chair playing with her toy keys. He said that she had a set of plastic keys, either two or three of them on a ring, and that she played with them all of the time. He recalled that the keys were *“everything”* to her. Gamma recalled that Grace went on the swing occasionally. He told the Commission that Mrs. X let her out on the swing for 20 minutes if it was a nice day. Gamma said that Grace was a *“loner”* and that she was *“happy in her own company”*. He thought that she did not like other children. He believed that one of the reasons for this was that she feared other children would take her keys and that she did not want that to happen.
- 4.127 Gamma thought that Grace presented *“well enough for anyone, very good”*. He did not see any difficulty with her presentation and said that, to him, she *“seemed okay”*. He had no view on her teeth and told the Commission that he would not examine a person's teeth. He explained that she prodded herself in the gums and he thought that it was a habit she had. He said that Mrs. X would get on to her for prodding her teeth. He recalled that her gums bled a little. Gamma thought that Grace wore nappies but he did not know much beyond that. The Commission is satisfied that he had no role in Grace's personal care.

- 4.128 Gamma said that Grace's behaviour was very good in restaurants. She sat down and had a meal the same as the others. He recalled, however, that if Grace became agitated in any way at a restaurant, Mrs. X would say "[Grace], *behave yourself*", and that Grace responded to that. Gamma said that she might take a "*little fit of laughing for no reason*". Gamma said that Grace was "*fairly good*" in the shops and that she pushed the trolley around with Mrs. X and that they got what they wanted.
- 4.129 Gamma said that Grace was always the same to him. He told the Commission that, over time, she was maybe a bit better in her behaviour in terms of sitting down quietly. Gamma did not know the level of Grace's understanding. He recalled, for instance, that sometimes she laughed at the television; however he did not know if Grace was laughing at what she had seen on the television or if she was laughing at something else. He said that Grace did understand up to a point; for example, he recalled that if Mrs. X asked her to wash up, she would do so. He also said that she reacted to her own name. Gamma was of the view that Grace was uninterested in things, although Mrs. X tried everything with her.
- 4.130 When he was asked about Mrs. X's evidence to the effect that sometimes in the house with her, Grace would suddenly start screaming, Gamma said: "*I never see her screaming. As I say she would take a fit of laughing for no reason*" and that "[s]he would start laughing, giggling to herself". Gamma also said that he never saw Grace banging her head, saying that he had "*never seen her that bad, no*". However, he said that the bus driver, Mr. H, told him that she banged herself on the bus to and from Day Service Provider A. Gamma said that he was away working most of the time and that, when he was not there, his door was closed. He said that Grace did not visit the outbuilding that he lived in prior to 2000 and, as far as he knew, she had never been in the outbuilding.
- 4.131 With regard to the Commission's inquiries concerning whether Grace had ever been subjected to sexual abuse, Gamma was adamant that he never saw Grace being sexually interfered with. In response to the Commission's inquiries concerning whether he had ever been involved in abuse, including sexual abuse of Grace, Gamma was adamant in refuting any such hypothesis. There was no evidence of any kind to the Commission to the contrary.

Findings on Gamma

4.132 There was no evidence of any kind upon which the Commission could conclude that Gamma was anything other than a neutral feature of Grace's life over the years. The evidence indicated that his engagement with Grace was somewhat remote. There was evidence to the Commission to suggest that Gamma's presence was of practical benefit to the household and to Grace as a member thereof. The Commission had no evidence that Gamma, as a male in the household, should have been a cause for any concern with respect to Grace's safety or well-being, having regard to the evidence provided to the Commission in its investigations of her care, and there was no evidence to the Commission that he had ever abused or mistreated Grace in any manner.

4.133 The Commission considered Gamma's evidence to be a reliable reflection of his memories of Grace in the household when he was there. Gamma was straightforward and helpful in giving his evidence to the Commission.

Beta

Preliminary

4.134 Beta's position in the household and the evidence of any involvement with Grace is set out below.

4.135 Beta was born and reared in the United Kingdom and his siblings still reside there. He is the eldest in his family of two brothers and four sisters. Both of his parents are deceased.

4.136 Beta first came to Ireland in 1973 or 1974 with a builder from the United Kingdom who had a building job in Ireland. This builder was married to Beta's cousin. In 1976 or 1977, Beta moved into a house with the builder and his family. He lived in a shed at the back of the house which had an open fire and a small bed. When the builder and his family moved back to the United Kingdom, they took all of their belongings with them and Beta moved into the house, where he slept on the floor.

4.137 Beta first met Mrs. X when he built the bathroom at Family X's house. Mrs. X's daughter saw where Beta was staying and thought his sleeping arrangements were very poor. She spoke to Mrs. X and it was suggested that he should stay with them.

Beta could not remember what the arrangement was at that time; however, he thought he could stay as long as he wanted.

4.138 Beta recalled meeting Gamma playing sport when he first came to Ireland, and again when he was building the bathroom in Family X's house.

4.139 Beta told the Commission that he paid some money in rent to Mrs. X and he said that he would help her with the house by buying some shopping and fuel. Beta confirmed that that was still the position at the time that he gave evidence to the Commission.

4.140 In her evidence to the Commission, Mrs. X said that Beta lived and continues to live in an outbuilding on the property. She said that he has running water but that he does not have a kitchen or a bathroom. Rather, he has access to the bathroom in the yard. He has a bed and a television in his room.

Beta's account on aspects of daily life and relationship to Grace

4.141 Initially when he came to Ireland, Beta worked for the builder he had travelled with. When that family returned to the United Kingdom, Beta started working in a different job and he continued to do that work at the time he gave evidence at the Commission.

4.142 Beta started work at eight o'clock in the morning. In the summer, he worked until six o'clock in the evening and until ten at night in the winter. He told the Commission that sometimes he had breakfast in the kitchen of Family X's house before Gamma drove him to work in the mornings. Beta does not drive. He said that Mrs. X and Grace would not be up in the morning before he left.

4.143 Beta told the Commission that he used the outside toilet and that, when he wanted to have a shower, he used the bathroom in the house. Mrs. X gave evidence that Gamma and Beta sometimes used the bathroom in the house. Mrs. X said that they could access the bathroom from the back without having to come through the house. This access was evident on the Commission's inspection of the property referred to earlier. Mrs. X said that there was a hand basin and toilet at the end of the garden that Gamma and Beta used.

- 4.144 Beta said that he got his meals at work and that, when the business that he worked for changed ownership, he came home for his evening meal. He said that Mrs. X provided a meal for him and he sat on his own in the kitchen to eat it while Mrs. X and Grace were watching television in another room. Beta said Gamma might also be watching television and Alpha could be there too.
- 4.145 Beta said he would hail whoever was in the house to let them know he was there and that, after he had eaten or had a cup of tea, he would go to his own room to watch television. Sometimes he worked with Gamma in the evening if there was a job that needed to be done or, occasionally, he might go and help out a neighbour who needed assistance with a job. Beta has a keen interest in sport and this takes up most of his free time.
- 4.146 Beta said his relationship with Mrs. X was “*great*”. He described her as a mother figure to him and to the rest of the household. He also described his relationship with Gamma in very positive terms, saying that they were like brothers and that they helped each other out. Similarly, he said that he had a “*brilliant*” relationship with Alpha.
- 4.147 Grace did not engage with Beta. He said that he would greet her but that was it. He knew that she could not talk but he did not have any clear idea of her disabilities. He considered that she was quiet and he did not remember her screaming or playing with her keys. He said that he thought Grace was happy with Mrs. X and that Mrs. X looked after Grace “*a thousand to one*”.
- 4.148 Beta did not see Grace having meals; she had her meal with Mrs. X and he had his out in the kitchen. However, he said that Grace had a “*good appetite*” and a “*big appetite*”.
- 4.149 Beta was not in a position to comment on the day-to-day activities of the house, as he said that he was generally not there. He knew from Mrs. X or Gamma that Grace got the bus to Day Service Provider A; however, he was not there when she was collected and dropped off.
- 4.150 Beta had no memory of Grace’s removal from the Family X household. He knew that she was gone but he knew nothing of the circumstances surrounding her departure.

4.151 Beta told the Commission that he did not see Grace abused in any way. In response to questioning at the Commission, he emphatically stated that he was never involved in any ill treatment or abuse of Grace, sexual or otherwise. There was no evidence of any kind to the Commission to the contrary.

Findings on Beta

4.152 There was no evidence upon which the Commission could conclude that Beta was anything other than a neutral feature of Grace's life over the years. The evidence did not indicate that Beta had any real engagement with her and there was no evidence to the Commission that he had ever abused or mistreated her in any manner.

4.153 From the evidence to the Commission with respect to Beta, he can be described as leading a very simple life. He gave helpful background information that was of assistance to the investigation. He did not have detailed evidence to offer with respect to Grace. The Commission considered that his evidence was useful on aspects of Grace's life at home, and that he provided such assistance as he was able to.

Impact

4.154 By the time that this Commission was established to investigate matters of significant public concern, including the questions posed with respect to whether or not Grace had been subjected to abuse, these persons, while not identified, had effectively become enveloped in a cloud of suspicion as to whether they had caused Grace to suffer any harm. The negative impact of this situation on each of them was evident to the Commission.

4.155 Although no particular assertions of wrongdoing were ever made against Alpha, Gamma or Beta, the insinuations attaching to the references in the narrative that developed in Grace's case to men either living in the house or coming to and going from it, were insidious. The Commission observed that the impact of being caught up in such a narrative that gained currency in the public domain was a difficult and, at times, a particularly stressful experience for the above persons.

5. Hospital visit – 27th March, 2009

Preliminary

- 5.1 After Mr. Smith became involved in Grace's case in 2007, he had asked that he be contacted and informed if any marks of concern were noted on Grace in Day Service Provider A. It was in these circumstances that the hospital visit, set out below, occurred in March, 2009.
- 5.2 The facts established and the Commission's findings concerning marks and bruising observed on Grace in Day Service Provider A on other occasions over the course of her attendance there between 1995 and 2009, are reported in Chapter 2 of this Volume. That Section of Chapter 2 includes the facts established about an earlier occasion in August, 2008 when Grace was taken to hospital in Waterford by Mr. Smith and Day Service Provider A personnel in connection with an incident of bruising to the area around Grace's eye.
- 5.3 On the occasion when Grace was brought to Waterford Regional Hospital in March, 2009, bruises that had been noted on Grace in Day Service Provider A earlier that day, and about which Mr. Smith was contacted, gave rise to a concern as to whether they were indicative of an assault of a sexual nature.
- 5.4 Aspects of this hospital visit and its aftermath are reported in:
- the Garda Volume⁸; and
 - Chapter 14 of Part 2 of Volume 1 of the Commission's report.
- 5.5 The focus of this Section is on whether or not, having regard to the evidence received by the Commission, the facts established concerning this hospital visit support a view that Grace was subjected to a sexual assault at that time.

The evidence

⁸ Volume 4 of the Commission's report is generally referred to as the Garda Volume.

The circumstances in which hospital visit occurred

- 5.6 On 27th March, 2009, when Grace was being showered in Day Service Provider A, certain marks were noted on her, recorded in the daily body chart as follows:

“1 two small scratches on the right side of [Grace’s] neck where it meets her shoulder

2 three small circular marks which are very close together just above her right breast... yellow in colour and appears to be bruising

3 two small bruises on her right thigh... very close together...appear to be faded/yellow in colour

4 five scratches on her left side. Three of the scratches are very close together. There are also two smaller scratches.”

- 5.7 In her note with respect to this, CW6 recorded as follows:

“[Grace] had diarrhoea this morning. [CW9], Relief [the local voluntary association] staff called [CW6] Programme Assistant... decided [Grace] needed to be showered. [CW9] Relief [the local voluntary association] staff and [CW6] showered [Grace]. See body chart dated 27/03/09. [Mr.] Smith, [Grace’s] Social Worker, was contacted. He met with [Ms D] [Clinical Nurse Manager 2] and [Ms B], social worker. [Grace] was taken to the accident and emergency. She returned home in the evening.”

- 5.8 In her evidence at the Commission, CW6 recalled that, when she and CW9 were showering Grace, they noticed a number of bruises. The bruises CW6 could recall in evidence were three small bruises on one of Grace’s breasts that were yellow in colour. When she noticed these bruises, she brought them to Ms D’s attention.

- 5.9 Ms D contacted Mr. Smith and told him that, when Grace was being showered at Day Service Provider A, staff had discovered certain unusual marks and bruising on her body, namely three small round bruises above her right breast, two or three small round bruises on her upper right thigh (outside) and scratches to her neck and upper

left side. This contact was made in accordance with what had been agreed with Mr. Smith, that anything of concern with respect to Grace would be brought to his attention.

5.10 Mr. Smith came to Day Service Provider A and met with Ms D and Ms B. They telephoned the Emergency Department in Waterford Regional Hospital, who advised them to discuss the matter with the Gardaí first.

5.11 Mr. Smith telephoned the Gardaí in Waterford who said that they would have members attend Day Service Provider A at around 2.00 p.m. Gardaí arrived at Day Service Provider A at approximately 3.40 p.m. The Gardaí returned to Day Service Provider A at 5.00 p.m. and advised that Grace be taken to the Emergency Department of Waterford Regional Hospital and, following the outcome of the initial examination, then to consider whether a referral to the SATU was appropriate.

Grace taken to hospital

5.12 Mr. Smith, Ms B, and Ms D then took Grace to Waterford Regional Hospital. Grace was brought to hospital because of concern or suspicions with regard to whether the bruises pointed to a sexual assault. Grace was examined by a doctor in the Emergency Department who, being concerned about the possible cause of the bruises, felt that the matter needed further investigation. Grace was duly referred to the SATU within the hospital.

5.13 The hospital notes recorded:

“...suspicious bruising and scratches on breasts and thighs.

Plan 1. Advised carers / social worker that injuries are suspicious in nature and that they should contact the police [and] sexual assault unit.”

5.14 Mr. Smith made a statement of complaint for the purpose of requesting the SATU’s examination of Grace.

5.15 The events surrounding Grace’s attendance at Waterford Regional Hospital on this day and her subsequent return to Mrs. X’s care are detailed in full in Chapter 14 of

Part 2 of Volume 1. This should be read in conjunction with this Chapter. For the purpose of this Chapter, however, the Commission is focused on the markings on Grace's body and the presence or absence of evidence in determining their cause.

- 5.16 This requires particular engagement with the report and evidence of Dr. Mary O'Gorman, Forensic Examiner attached to the SATU, who was on call that evening, and of the results of forensic testing of samples taken in the course of that examination.
- 5.17 The observations section of the Emergency Department's record stated that there was "*no obvious distress*" on Grace's part. Mr. Smith confirmed in his evidence that she was not distressed at the hospital. Ms D told the Commission that Grace did not want to stay quietly on her bed in the hospital, but wanted to get up and wander around. Ms C, the Director of Nursing in the local voluntary association of which Day Service Provider A was part, who subsequently arrived at the hospital from Dublin, was of the view that there was nothing unusual about Grace's walking the halls of the hospital, since Grace walked all of the time. Grace's desire to walk around the hospital that day was not considered a sign of distress by those who accompanied her.

SATU

- 5.18 The SATU is a separate, designated unit within Waterford Regional Hospital. The Commission heard that if a case came *via* the Gardaí to the nurse in charge of the SATU or to the Director of Nursing at Waterford Regional Hospital, the practice was for the nurse to contact the Forensic Examiner attached to the SATU who was on call. A time would then be organised for attendance at the SATU, where the alleged victim would be assessed and examined.

Dr. Mary O' Gorman, Forensic Examiner

- 5.19 Dr. Mary O'Gorman, general practitioner and forensic examiner with the SATU, examined Grace on the night of 27th March, 2009.

Marks as noted

- 5.20 Dr. O'Gorman noted the following marks in the course of her examination:

- Grace had bruising over her right hip which was round and 2.5 x 1 centimetres in measurement. The bruising was situated 11 centimetres from the iliac crest (the hip) and it was on the outside of the leg;
- Grace had a scratch mark on the left upper neck, three centimetres long. It was 10 centimetres from the left ear lobe;
- on the right side of the chest, there was yellow bruising measuring 3 x 2 centimetres;
- on the left upper chest, there was a scratch mark, measuring 8 x 8 centimetres. That was situated 16 centimetres from the left axilla (the left armpit);
- there was yellow bruising, one centimetre round, on the left chest and three centimetres from the midline;
- on the left thigh, there was some red mottling;
- on the inner right leg, there was an inner round scar and it was one centimetre in diameter;
- there was a round bruise which was on the right outer knee area and was one centimetre in diameter;
- above the right anterior thigh, there was some red mottling as well;
- there was a 5.5 centimetre scratch mark on the right lower arm and it was situated four centimetres from the ulnar process (the wrist); and
- up the right arm there was an eight centimetre scratch mark and that was situated seven centimetres down from the glenoid process (the shoulder).

Conduct of the examination

5.21 The examination took place at approximately 9.30 p.m. and lasted approximately one hour and 30 minutes. It had to be carried out having regard, first, to the safety of the

patient and, secondly, to the safety of those present in the room. Dr. O’Gorman explained that, in general, patients tended to be nervous; they needed reassurance and for the examination to go slowly.

- 5.22 Dr. O’Gorman’s memory of Grace was that she was “*disturbed and prone to movements and could kick out or flail out.*” This, she said, was understandable where the examination involved somebody who could not fully cooperate or understand the process.

Examination findings

- 5.23 With respect to Grace’s genital and anal examination, Dr. O’Gorman made a note that she had no perineal injuries. In evidence, Dr. O’Gorman told the Commission that there were no injuries noted there and that she found no redness, scratches, or bruising. Dr. O’Gorman’s examination notes included an image of the female genitalia. She confirmed to the Commission that her finding of no injuries referred to the entirety of the area of the diagram. Dr. O’Gorman found the natal fold (the fold at the rectum, between the buttock where it folds in) to be normal. There were no injuries and no genital warts noted at the perianal/anal margin. The report concluded no injury and “*No peri anal injuries noted. Good sphincter muscle reaction.*”
- 5.24 Dr. O’Gorman did not conduct an internal rectal examination, as she said that Grace was “*very resistant*”. Bearing in mind Grace’s safety and the safety of those in attendance and, having found no external injuries, Dr. O’Gorman said that she did not feel that there was any reason to examine Grace’s rectum internally with a scope. External swabs were taken.
- 5.25 Having no history or information with regard to the following, Dr. O’Gorman noted the word “*unsure*” for the following standard headings on the form to be completed for the examination, namely “*Penile/Oral penetration (male to female); penile/Oral penetration male to male; penis in mouth of complainant; penis in mouth of suspect; penile/Vaginal penetration; penile/Anal penetration; digital penetration; object penetration; ejaculation on the skin/hair/clothes; Kissed/licked/bitten; Condom; Lubricant; Spermicide.*”
- 5.26 Under the query of “*Menstrual Bleeding, Bleeding due to genital / anal injury*” and “*Bleeding from any other part of the body*”, Dr. O’Gorman’s finding was “*no*”.

- 5.27 A mouth swab was taken from Grace to check for the detection of semen. One sample of head hair for the identification of semen was taken and one control sample. A swab and cuttings were taken from the nails of both of Grace's hands. Two samples/swabs were taken from the skin. One vulva sample was taken. Dr. O'Gorman was satisfied that it would not have been safe, from Grace's perspective, to have taken internal swabs of the vagina due to her likely reaction and her condition. In this regard, Dr. O'Gorman said: "*Her reaction was very violent almost at times*". One pubic hair sample was taken and one control sample. A rectal swab was taken for the detection of bodily fluids if anal intercourse had occurred within three days. In the interest of safety and owing to issues of trauma, Dr. O'Gorman did not carry out blood samples on Grace.
- 5.28 The examination included carrying out a pregnancy test. The result was negative.
- 5.29 Dr. O'Gorman's handwritten notes were completed on the night of her examination.
- 5.30 These examination notes remained on the SATU file until such time as An Garda Síochána requested a typed report from Dr. O'Gorman. Dr. O'Gorman's evidence was that she usually typed the report from the handwritten notes she made during the examination once the request came from the Gardaí. Dr. O'Gorman's report was not sought from her until August, 2010. The circumstances in which this occurred, together with the handling of the swabs taken, are reported in the Garda Volume. It is intended that the Garda Volume be read in conjunction with this Chapter.

Dr. O'Gorman's overall findings

- 5.31 Dr. O'Gorman's report set out the following:

"This patient presented to A&E Dept., Waterford Regional Hospital, with a history of body injuries noted by her carer while showering, which had not been present the previous time she had showered her. As the patient had profound intellectual disability a history could not be collaborated [sic] and due to the injuries noted the Gardaí were contacted and the patient was forensic[ally] examined and limited sampling undertaken within safety and comfort limits due to the patients intellectual capacity."

- 5.32 In her report, Dr. O’Gorman’s description of alleged assault included that “[Grace] was also noted to be more ‘restless’ recently and was ‘laughing’ a lot that day which would be unusual behaviour from her. She was referred to A&E and thence to Waterford Gardaí and SATU.”
- 5.33 In her notes of the examination, Dr. O’Gorman indicated that it was “*uncertain*” in response to the question: “*Did sexual assault occur*”?
- 5.34 Dr. O’Gorman did not come to any definite conclusion as to how the marks on Grace had been caused. She said that they were scratch marks and she could not say how or what caused them.
- 5.35 Dr. O’Gorman said that the marks should not have been there and “*that was the concern*”. The examination did not resolve the concern one way or the other. She said that any further investigation would be a matter for the Gardaí.
- 5.36 During her evidence at the Commission, Dr. O’Gorman said that the fact that the bruises were yellow would indicate that they were likely over 18 hours old. She also observed that bruises generally “*start red, blue, black, purple and then [turn] yellow*”.

Grace’s general presentation

- 5.37 Dr. O’Gorman told the Commission that Grace’s hair was normal and clean and not matted or dishevelled. She said that Grace’s body, hands and nails were clean. Grace had been showered and her clothes had been changed that morning in Day Service Provider A.
- 5.38 Dr. O’Gorman did not have any concerns as regards Grace’s body weight or in relation to her general care. On an overall initial assessment, she had no concerns about any neglect. Dr. O’Gorman’s impression was that, insofar as neglect was concerned, there was no issue with Grace, other than the injuries that she had observed in the course of her examination.⁹
- 5.39 Dr. O’Gorman’s impression, as conveyed to the Commission, was that “[o]ther than the injuries, [Grace] looked well kept and well cared for.” Dr. O’Gorman observed

⁹ Dr. O’Gorman’s evidence was somewhat unclear at this point and this lack of clarity appears to have arisen from a typographical issue. Dr. O’Gorman’s opinion seems to have been that, based on her examination, there was no issue with Grace, other than the bruises that were identified on 27th March 2009.

that Grace's clothing was appropriate to her age, it was not torn in any way and it was in good order. Dr. O'Gorman said that Grace was thin but not emaciated.

- 5.40 Dr. O'Gorman commented that, when dealing with a person with an intellectual disability, she would expect some behavioural matters to arise. She said that being in a strange unit would cause Grace to be a bit nervous and upset.
- 5.41 Save for the preparation of her report in August, 2010, Dr. O'Gorman had no further involvement in Grace's case following her examination in the SATU on the evening of 27th March, 2009.

Mr. Smith's note

- 5.42 On the particular issue of the examination, Mr. Smith's note with respect to the attendance at the SATU recorded that "[n]o specific evidence of sexual assault was found at the time". Mr. Smith noted that the injuries (the bruises) were over 18 hours old and of uncertain origin.
- 5.43 In a note entitled "Case Summary", which he typed up the following Tuesday (31st March, 2009), Mr. Smith recorded that the bruises were yellow in colour and that staff at Day Service Provider A "*felt that they were suggestive of 'finger tip' bruising*". Mr. Smith's note also read, "*[i]t was of particular concern that the bruising was on an area not normally associated with being grabbed... and [was] therefore possibly sexual in nature.*"
- 5.44 Ms D told the Commission that "*[w]hen the bruises were brought to my attention there would have been conversation, I suppose more so in relation to the area that they were and I suppose whilst we are not qualified to say that they are fingertip bruising we would have conversations in relation to 'are they of concern'?*".
- 5.45 Looking back, Ms D said that she could see that it was something that the staff would have tried to tease out among themselves, as to whether they were bruises of concern that needed to be notified to Mr. Smith. Because of the area they were in, Ms D said that she would have had a concern at the time as to whether they were sexual in nature.

- 5.46 Mr. Smith also made a note of his view that the marks *“could have been fingertip injuries consistent with [Grace’s] being held back, except that the sites were unusual in this regard”*. In her evidence to the Commission, Dr. O’Gorman confirmed that she did not discuss this with Mr. Smith. This was, therefore, the view of the situation as recorded in Mr. Smith’s note and not the opinion of the doctor.

Contact with Mrs. X on Grace’s returning home

- 5.47 The circumstances which led Mr. Smith to decide to return Grace home from the hospital are considered and reported upon in Chapter 14 of Part 2 of Volume 1 in the context of the management of Grace’s case by the HSE on the night in question. The extent of the conversation with Mrs. X about why Grace had been brought to hospital for investigation is reported below, relevant as it is to what discussion, if any, there was with Mrs. X about the marks on Grace’s return home.
- 5.48 At around 11.00 p.m. or shortly afterwards, Mr. Smith decided to return Grace to Mrs. X’s house. Ms D telephoned Mrs. X to say that Grace was on her way home. After leaving the hospital, Ms B, Ms D, Mr. Smith, and Grace travelled back to Day Service Provider A on the minibus that belonged to the service and Mr. Smith then drove them back to Grace’s home in his car. Mr. Smith’s note of the events of 27th March, 2009 recorded that, upon their arrival at Mrs. X’s home, *“[a]gain [Grace] went up the path first and waited outside a side entrance before Mrs [X] brought her in the front door”*. This was something that Mr. Smith had observed Grace doing previously.
- 5.49 The matter of which door Grace went to on arrival at Mrs. X’s house had also been given some significance by Mr. Smith and Ms B on the previous occasion in August, 2008, when they had brought Grace back to the house after taking her to hospital. What is referred to as the side entrance was a door at the front of the house to the left side, a very short distance from the front door. The layout of the house exterior and interior is reported in Chapter 3 of this Volume.
- 5.50 In her evidence to the Commission, Mrs. X said that Grace always went in the door to the side of the house, and that this was the door that was mainly used by the household. She described how Grace would get off the bus, come in the gate and go in the side door. This was the way into the house that was nearest to the toilet. Grace would always have to go to the toilet when she came back to the house. In relation to

the front door, speaking of their own use of it, Mrs. X said “*we never used the front door, it’s never used*”.

- 5.51 While Ms D did not remember Grace going to the side door, she said that she knew about it because it had been discussed many times since then.
- 5.52 Although this was a matter of comment, it should be noted that no question about which door Grace ordinarily used when she came back to the house, was ever raised with Mrs. X, on this occasion or on any other occasion by any HSE official.
- 5.53 Insofar as a concern of some kind was implied about which door Grace approached, the Commission is not satisfied that there was anything unusual or significant about Grace’s arrival at the house following this hospital visit or that going in or out through the side door of a country house was of itself outside the norm.
- 5.54 Mrs. X said that it was nearly midnight when Grace arrived back with Mr. Smith, Ms D, and Ms B. In describing how Grace was on her return, Mrs. X said: “*She came in to me, put her arms around me and cried for being away*”. She recalled Grace as running in, grabbing and hugging her. Mrs. X said Grace was very upset. Grace stayed with Mrs. X while she had a brief conversation with Mr. Smith, Ms B, and Ms D. Mrs. X recalled that “*I couldn’t get rid of her*” as “*she was so happy to be back*”. Mrs. X became emotional in recalling this in her evidence at the Commission. In her note of events, Ms B wrote that “[Grace] *walked towards [the] door out of sitting room left of the house. [Mrs. X] held her hand and asked her how she was. [Mrs. X] held [Grace’s] hand for [the] duration of conversation in [the] sitting room*”.
- 5.55 Mrs. X recalled that they came into the room and they had a short conversation. She remembered that Ms D was in a hurry. Mrs. X’s evidence was that she asked them what was wrong and that Mr. Smith told her that Grace had had to go to hospital because of bruising. Mrs. X said that, when she asked who did that and how they had got on at the hospital, Mr. Smith explained that Grace was too upset and that they had been unable to examine her there. He said that Grace was tired and asked Mrs. X to give her a shower or a bath and go to bed. According to Ms D, Mrs. X came across the same as “*always*”, which, she said, meant that there was not any level of defensiveness on Mrs. X’s part. She described Mrs. X as being “*matter of fact*” about it all.

Contact with Mrs. X on 27th March, 2009

5.56 Before Grace was taken back to Mrs. X's from Waterford Regional Hospital, there had been a number of contacts with Mrs. X after the bruising was noticed, namely at 4.30 p.m., 8.15 p.m., and at around 11.00 p.m.

5.57 At 4.30 p.m., Ms D telephoned Mrs. X to inform her that Grace had bruising, which needed to be examined in hospital. Ms D told the Commission that her conversation with Mrs. X was "very, very short". In this regard, Ms D told the Commission that the reason for this was that, on the previous occasion in August, 2008 when Grace had been taken to the hospital by Mr. Smith and Ms B, *"I had been asked to contact Mrs. [X] and say that [Grace] would be late home and I had been asked not to advise her of where the actual bruising was but, unfortunately, I had told her where the bruising was"*. This previous occasion on which Grace presented at Waterford Regional Hospital's Emergency Department is reported upon in Chapter 2 of this Volume and in Chapter 7 of Part 1 of Volume 1.

5.58 Ms D said that, on this occasion, she was much more circumspect in the telephone call to Mrs. X. She said that Mrs. X took the information from her and she did not recall Mrs. X as being overly concerned in that short call.

5.59 Ms D's note of the call made recorded that:

"At 4:30 pm I contacted Mrs. [X] and informed her that [Grace] would not be returning to her home at the usual time. I explained that during showering staff had observed marks on [Grace] and these required to be investigated. I told her [that] I would contact her later. Mrs. [X] stated that [Grace] was fine when she left in the morning."

5.60 Mrs. X recalled getting a telephone call from Day Service Provider A (she could not remember who in Day Service Provider A telephoned her) and being told that Grace needed to be seen at the hospital due to bruising, but without being given any detail as to the location of the bruising. This was confirmed in Ms D's evidence.

5.61 Ms D later telephoned Mrs. X from the hospital. Her note of this was as follows:

"At 8:15pm I contacted Mrs. [X] and informed her that I would contact

her again later when I had any news re [Grace]. At this point Mrs. [X] asked if [Grace] was ok [and] I replied yes. She also asked if [Grace] would be returning home that evening and I told her I would contact her later when I had news."

5.62 In her evidence, Ms D had a vague recollection of that conversation with Mrs. X and of its being different to her brief earlier call, when Mrs. X simply accepted the information that she was given. In the second conversation, Ms D said that Mrs. X showed some concern about Grace.

5.63 Ms D further noted that later that night *"on arrival to Mrs. [X's] house, [Ms B], [Mr. Smith] and I entered the sitting room and a brief discussion took place between [Mr. Smith] and Mrs. [X]. Mrs. [X] stated that [Grace] always had a mark on her left shoulder/upper arm. She then said that she also had a mark on her left thigh. She later said the mark on her arm was only there for the last two weeks and that she was [going] to notify [Day Service Provider A] but didn't want [Day Service Provider A] staff to think she was blaming them."*

5.64 In giving her evidence, Mrs. X only remembered one occasion, rather than two, when Grace was taken to hospital and it was this visit that she recalled, not the earlier one. With regard to Ms D's note above, Mrs. X agreed that, broadly speaking, it tallied with her memory of a conversation with Ms D on this occasion.

5.65 Ms B's note of the conversation when Grace was returned home recorded as follows:

"[Mr. Smith] advised [Mrs. X] that marks were observed on [Grace's] body.

[Mrs. X] stated that [Grace] always has marks on [her] upper left arm from someone holding on to her arm tightly, demonstrated hold on [Grace]. [Mr. Smith] advised [Mrs. X] that if there are bruises on [Grace's] body, [Mr. Smith] should be told.

[Mrs. X] stated that she was going to tell Day Service Provider A but didn't want staff to think she was blaming them.

[Mrs. X] stated that [Grace] also has marks on upper leg, indicated left

thigh, 'always has a bruise on there' (indicated left thigh), or always on there (indicated upper arm), always in the last two weeks".

5.66 Mr. Smith also recorded the events upon arrival at Mrs. X's house. He wrote:

"[W]e did not discuss the bruising but [Mrs. X] wanted to talk to us about it.

[Mrs. X] then said that [Grace] had 'always' had bruising to her upper arm (she showed us where she thought the bruising was) and she felt that this must be caused by someone grabbing her. She also had had bruising on her left thigh for the last two weeks.

I told her that she needed to pass this information on to ensure that [Grace] was safe. She said that [Grace] was safe but that she did not want anyone to think that she was trying to blame [Day Service Provider A] for the bruising. [Mrs. X] said that she had been going to tell [Ms D] about the bruising this morning."

5.67 Mr. Smith's note included his observation as follows *"(Note that the bruising described by [Mrs. X] was the same type of injury but the wrong areas of the body. Her statement was also inconsistent with what she had told [Ms D] earlier that day.)"*

5.68 In her evidence, Ms D could not recall Mrs. X as saying that Grace did not have bruises coming into Day Service Provider A that morning. Her memory of their telephone call was prompted by the documentation considered above, in which she had recorded Mrs. X as having said that Grace was fine when she left that morning.

5.69 In the context of a later conversation with Mr. Smith about notifying Mrs. X of the location of the bruising and ascertaining a possible explanation, Ms B in evidence said that:

"first of all, it was that [Grace] had no bruises when she left that morning, that was the earlier conversation with [Ms D]. That evening [Mrs. X] was talking about [Grace] always has bruises on her arm, she always has bruises here, but we hadn't put it to her that there was bruising there that the doctor feels is over 18 hours old on her

breast...

- 5.70 Mrs. X told the Commission that she could not remember having any discussion with Mr. Smith about bruising to Grace's upper arm when Grace was returned home. She said that Grace always had a mark on her arm or one of her shoulders and probably still had it. She said that Grace had "*lots of marks*" on various parts of her body as a result of scratching and people grabbing her and that she could well have had those described in the notes.
- 5.71 Mrs. X told the Commission that that was what she would have thought would have caused bruising, namely someone grabbing Grace. Mrs. X said that "*everybody was grabbing [Grace]*", and that this referred to any of the "*kids*" that she had staying over the years. Mrs. X said that "*the lads [on the bus] would try and hold her*" and that the bus driver would have said this to her. Mrs. X said that "*he would have told me how bad she was, laying down on the floor on the bus*".
- 5.72 Mrs. X said that she did not know anything about Grace's being grabbed in Day Service Provider A. It is important to observe that, in giving this evidence, Mrs. X was not suggesting that this grabbing was associated with anything of a sexual nature, but rather that this kind of grabbing and pulling was something that did occur. The circumstances of Grace's bus journeys to and from Day Service Provider A are reported in Chapter 2 of this Volume.
- 5.73 The Commission is satisfied on the evidence that the exchange between Ms D and Mrs. X, in which Ms D mentioned to Mrs. X that staff had observed marks on Grace and Mrs. X had said that Grace was fine when she left that morning, was short and that there had not been any specification as to what the marks were, much less any indication as to why they were thought to require hospital investigation.
- 5.74 Ms B said that, while Mrs. X had been told Grace had bruises on her and been brought in for an assessment, Mrs. X was not told that Grace had "*bruising to her breast*" or that they thought that the bruising was "*concerning*".
- 5.75 At the Commission, Mrs. X had no memory of the second telephone call. The extent of what Mrs. X was told by Mr. Smith, Ms B, and Ms D was that Grace had bruises and that she had been brought to hospital for assessment. They did not discuss the bruising with her. She was not told about the fact that there was bruising above the

right side of the chest or of any particular concern in that regard. Mrs. X was not told that the doctor thought that these bruises were about 18 hours old and she was not asked for her view as to how they might have arisen. She was not told that Grace had been seen in the SATU, or that there was any issue of a sexual concern.

5.76 In the above circumstances, Mrs. X was not asked by the HSE or by Day Service Provider A personnel at this time, or indeed at any time later, if she could shed any light on how the bruises on the right side of Grace's chest might have come about. There was no detailed review or enquiry at the time about Grace's activities at home, on the bus, in Day Service Provider A, or at her activities over the course of that week in connection with this bruising. Nor was the cause of these particular bruises established.

5.77 Mrs. X was well aware that Grace was showered and changed and taken swimming regularly in Day Service Provider A. On the evidence to the Commission, the brief conversation with Mrs. X when Grace was returned home from Waterford Regional Hospital, about why Grace had been taken to hospital, did not involve any particular discussion on bruising, beyond what has been reported above. There was no discussion about the specific bruising, namely the marks on the right side of Grace's chest, that was concerning Mr. Smith, Ms B, and Ms D.

Day Service Provider A's notes for the period around this hospital visit

5.78 As set out below, there had been a number of other entries in Day Service Provider A's daily records with respect to Grace that week.

The period leading up to 27th March, 2009

5.79 Grace had been swimming three days earlier, on Tuesday, 24th March, 2009. This was an occasion when Grace took off her swimming togs in the dressing room in the swimming pool and banged her head off the wall of the toilet cubicle. A note of Wednesday, 25th March, 2009 recorded that Grace had been banging her head and elbow off the wall while she was getting ready for swimming.

5.80 On Thursday, 26th March, 2009, CW6 made a note that Grace was restless after eating and began to pull out of staff for tea. Grace would physically pull the staff. This

was a feature of her behaviour that was reported by various persons who were involved in her care from time to time.

The period following 27th March, 2009

- 5.81 On 31st March, 2009, there was an entry in the body charts about the day's activities for Grace as follows:

"[Grace] went swimming this morning with [CW6, Programme Assistant], [Mr. M], Nurse and [CW2, Programme Assistant]. [CW6] dressed [Grace]. Both [CW6, Programme Assistant] and [CW2, Programme Assistant] worked with [Grace] in the pool. [Grace] appeared to enjoy her time spent in the pool and she was laughing. [CW6, Programme Assistant] showered [Grace]. [CW2, Programme Assistant] dressed [Grace].

In the afternoon [Grace] appeared to enjoy a 40th birthday party for one of the other service users. See body chart dated 31/3/'09."

- 5.82 On this chart, CW6 recorded that *"[Grace] has a small scratch on her left side of the chest. [Grace] has a scratch on the right side of her stomach."* Ms D countersigned the note. CW6 had no recollection of these marks at the Commission. CW2 also had no recollection of the marks.
- 5.83 There was no evidence that these marks were raised as an issue at this time. The marks were not regarded as warranting notification to the HSE and there was no evidence that any further investigation took place. The Commission heard evidence that Grace regularly had scratches which did not cause any particular concern for her welfare.
- 5.84 CW6 gave evidence that they went swimming from Day Service Provider A once and possibly twice a week. Grace would always go on the outing, unless she did not want to. In relation to minding Grace at the pool, it was of note that one staff member would work with Grace, while the other staff member would work with all the other service users in the pool. This was because of Grace's level of physical activity and her high care needs.

- 5.85 On 2nd April, 2009, a body chart signed by CW6 recorded “*four small scratches on [Grace’s] neck.*” CW6 had no recollection of these scratches when giving evidence to the Commission. Mrs. X was not contacted by Day Service Provider A in relation to this entry and the marks were not regarded as requiring notification to the HSE. There is no indication that any further investigation took place. As reported, Grace regularly had scratches that did not cause any particular concern for her welfare.

Visit to Sexually Transmitted Infections Clinic

- 5.86 During Grace’s hospital visit on 27th March, 2009, it was not possible to take certain required samples from her and so an appointment was made for her to attend a Sexually Transmitted Infections Clinic for further examination. Grace was brought there by Mr. Smith on 25th May, 2009, accompanied by Ms D.
- 5.87 In his note of 25th May, 2009, Mr. Smith noted that Grace did not “*cooperate*” during an attempted internal examination but that blood and urine tests were completed successfully. This was Ms D’s recollection also. Mr. Smith contacted the Sexually Transmitted Infections Clinic on 16th June, 2009 to get the test results. These tests were clear: there was no infection.

Analysis of swabs – Forensic Science Laboratory

- 5.88 The swabs taken from Grace on 27th March, 2009 were ultimately forensically examined at the Forensic Science Laboratory (“FSL”) on 30th June, 2011.
- 5.89 The reason for the delay in submitting these samples to the FSL for analysis is reported in the Garda Volume.
- 5.90 The result of that analysis was that the samples were negative; they showed no evidence of the presence of semen.

Findings – hospital visit

- 5.91 The fact of this hospital visit and Grace’s referral to the SATU resonated as a cause for concern throughout subsequent commentary within the HSE and the local voluntary association about Grace’s case. That Grace had been seen in the SATU was often taken as suggesting that that, in itself, supported a concern that she had

been subjected to a sexual assault. There can be little doubt but that it was appropriate to have referred Grace for examination to the SATU, once she was in the hospital. The hospital did not have a history with respect to how the bruising and marks had occurred and, of course, Grace could not give any account. She was brought to hospital for investigation because of the view taken that the bruising and marks were suspicious in nature. No treatment was required or prescribed.

- 5.92 The external physical examination of Grace's genital and anal area at the SATU did not disclose any injuries. The FSL's later analysis of intimate swabs for semen proved negative.
- 5.93 With respect to the scratches and bruises, Dr. O'Gorman did not come to any conclusion as to how they might have been caused, as she simply did not have information about that. In the absence of a history, the existence of such marks was, naturally, a matter of concern. Dr. O'Gorman's view – which was a perfectly reasonable one – was that any further investigation to establish the cause of the marks would involve investigation by the Gardaí and include gathering the relevant history and interviewing people.
- 5.94 The extent of the conversations with Mrs. X concerning this bruising, as established on the evidence, has been reported above. The Commission is satisfied that there was no meaningful discussion with Mrs. X as to how Grace might have sustained such bruising. On the contrary, a deliberate approach was taken not to disclose the location of the bruising to Mrs. X, either when first notifying her that Grace was being taken to hospital for examination, or when Grace was brought home from hospital, in particular insofar as the bruising referred to three small round yellow bruises above her right breast.
- 5.95 The Commission is satisfied that there is no evidence to conclude that the marks observed on Grace on 27th March, 2009 were caused or occasioned in the course of a sexual assault upon her person. The marks may have been obtained in a variety of other circumstances, such as Grace's being grabbed or held or pulled back, either at home, on the bus, at swimming, going to and from swimming, or at play. The cause of this incident of bruising cannot be established. However, having regard to all of the evidence considered by the Commission with respect to this hospital visit on 27th March, 2009, the Commission cannot be satisfied that the circumstances of that visit support a view that Grace had been subjected to sexual abuse at that time.

Part B: Evidence of events post-dating Grace's move to a residential placement in July, 2009

6. Introduction

- 6.1 The circumstances surrounding the decision by the HSE to move Grace from her home with Mrs. X into a residential placement on 17th July, 2009, as well as the decision to expedite the move, and the manner in which this move was effected is addressed in Part 2 of Volume 1, particularly Chapter 20.
- 6.2 There were no preparatory or transitional measures of any kind put in place for Grace before this move. Grace arrived from home to her day placement as usual by bus on the morning of 17th July, 2009 and was taken directly to the residential placement within the local voluntary association that day without returning home again. Grace was removed from the world she knew and from Mrs. X, her former foster mother and sole carer, and placed in a new environment that was strange to her, to live with and be cared for by care staff whom she had not previously encountered.
- 6.3 The effect of this move on Grace was profound. The evidence heard by the Commission with respect to this is reported below.
- 6.4 In Part B of this Chapter, the Commission reports upon Grace's presentation, her behaviours and the state of her mental health following her move from Mrs. X's care into the residential placement. The Commission will examine evidence of the local voluntary association staff who witnessed Grace's behaviours at that time, as well as that of medical professionals involved in her case, namely Dr. Syed, Dr. Ferrari, and Dr. Moran, and their views on the cause of those behaviours, particularly whether it had an underlying sexual basis. The Commission will also consider the evidence of Dr. Caffrey who, although he had no direct involvement with Grace, prepared a report for the HSE in 2010 which addressed, *inter alia*, the question of whether or not she had been sexually abused in the past.
- 6.5 From the medical evidence provided to the Commission, the most significant deterioration in Grace's presentation, behaviours and mental health occurred in the initial year or two following the move. For the purpose of this Chapter, in order to understand the impact of the move upon Grace and to establish, insofar as it was possible to do so, the reason for the rapid and significant decline in her health, the

Commission's investigations focused on this deterioration and on the evidence with respect to behaviours at this time. Grace was placed on certain medications following her move into residential care and remained on medication at the time of the Commission's investigations. Paragraphs 11.64 to 11.68 below refer to the impact of the decline on Grace of her mental health and set out details of the resultant regimen which was put in place for her at the residential placement with the local voluntary association.

- 6.6 Specifically, the Commission considered the relevance of this evidence of Grace's deterioration as to whether or not it assisted in establishing if she had previously been subjected to sexual abuse. In this regard, it was necessary for the Commission to examine the evidence with respect to the impact upon Grace of the move and the manner in which she struggled to cope with this change.

7. Grace

- 7.1 The Commission has previously observed that its work under the Terms of Reference involves inquiry into what would otherwise be wholly private aspects of a person's life. However, the facts established by the Commission concerning Grace's acute distress and her maladaptive behaviours in the period following her move from her home into a residential placement in July, 2009 and the psychiatric treatment that she required associated with the effective collapse in her mental health in the period following her move, are matters that are of fundamental importance to an understanding of her presentation in the period following the move and are reported upon accordingly.

Attachment and transition

- 7.2 The precise circumstances in which Grace's move to the residential placement occurred are reported in detail in Chapter 20 of Part 2 of Volume 1. In December, 2008, well before the move took place, the HSE had received a report on Grace's care planning from Mr. McGovern, Consultant Psychologist, which had adverted to the use of respite to prepare Grace for eventual transition to a "*group home setting*". The report had also stated that Mr. McGovern did not envisage that Grace would have any difficulty making that transition into a group home setting as he did not consider that she had a significant attachment to Mrs. X.

- 7.3 When Grace was moved from Mrs. X's in July, 2009, the HSE had not put in place any transitional arrangements, such as respite, which might possibly have eased her move by familiarising her with her new environment and lessening any potential adverse effects of a sudden separation from her carer of 20 years, Mrs. X.
- 7.4 When Grace's mental health deteriorated significantly following her move to residential care, those treating her, namely Dr. Syed and Dr. Ferrari, considered that this might have been caused by her separation from Mrs. X and that there might be some benefit in enabling Grace to have contact with Mrs. X.
- 7.5 These matters are reported on in further detail below.

Discussion of attachment before Grace's move

- 7.6 As reported upon in Chapter 10 of Part 2 of Volume 1, before completing his 2008 report on Grace, Mr. McGovern spoke to Mr. Smith on the telephone on 4th November, 2008. Mr. Smith's note of their conversation recorded that, among the matters they discussed, he asked Mr. McGovern how Grace would fare if she moved from Mrs. X's, and especially in relation to her missing Mrs. X and her home. He noted that Mr. McGovern's view was that Grace was *"unlikely to be able to sustain much in the way of an attachment to people or places"* and that Mr. McGovern had said that Grace was functioning at the age of a nine to twelve-month old baby, retaining certain behaviours only through repetition. Mr. Smith's note recorded that Mr. McGovern did not envisage *"attachment issues, such as loss and separation, that would merit the necessity of an access arrangement."* While Mr. Smith did not recall this telephone call during his evidence, he remembered having spoken to Mr. McGovern about the matter.
- 7.7 Mr. Smith told the Commission that the reason he had raised the issue of Grace's attachment to Mrs. X with Mr. McGovern was because he thought it inevitable that Grace would be moved from Mrs. X at some point in time. While Mr. Smith said that he doubted that a move would have an impact on Grace from an emotional point of view, he said that he nonetheless wanted to know Mr. McGovern's expert opinion. Mr. Smith said that this would not preclude the HSE from moving Grace, but that the emotional impact of the move and Grace's *"emotional presentation"* still had to be considered.

7.8 In the “Summary and Conclusions” to Mr. McGovern’s report, he stated as follows:

“1. [Grace] who is now 30 years of age and in placement with Mrs. [X] for the past 20 years, was seen for psychological review in order to evaluate her needs and plan accordingly.

2. She presents with a profound intellectual disability, has very limited communication skills and understands instructions at a rudimentary level.

3. The current care-taking arrangement with Mrs. [X], which was entered into 20 years ago is now becoming of a more time-limited nature, given this woman’s advancing years. Also [Grace] has a requirement for a quality of life experience within a group home, where her social and emotional needs may be more appropriately met in the context of relationships with peers.

4. In the short to longer term a number of initiatives discussed with Mrs. [X] focused on the following:

a) The use of respite to prepare [Grace] for eventual transition to a group home setting

b) The need for a planning meeting to take place involving [Day Service Provider A] personnel and Mrs. [X] to examine personal outcomes measures in relation to [Grace]. This in turn may allow for the development of more effective contact between this family and the local public health nurse and social worker.

5. I do not envisage that [Grace] will have any difficulty making the transition to the group home, as I feel her attachment to Mrs. [X] is not so significant that she will have any difficulty making that adjustment.”

Issues with respect to attachment and transitional measures

7.9 The evidence of Mr. McGovern and Dr. Ferrari regarding the issue of attachment and the matter of transitional measures associated with any move of Grace from the

home of Mrs. X into a residential placement is reported below and is relevant to considerations about Grace's presentation after her move and about the impact of the move on her.

- 7.10 At the Commission, Mr. McGovern said that it was possible that he saw attachment as something which he needed to report upon at the outset but that, because of Grace's profound intellectual disability, he did not see it as something very significant. He said:

"I possibly didn't see it as a priority or as something very significant because I suppose bearing in mind that she presented with a profound intellectual disability. I suppose in our experience we would find that certainly adults with profound intellectual disability have very transient bonds with carers, with nursing staff, and it is not as, let's say, discriminating as someone who is of a higher cognitive ability".

- 7.11 Referring to his experience of institutional settings, Mr. McGovern said that he generally found that if a member of staff retired or moved on, there would be a brief period of upset for the person being cared for, but that the person would re-adapt and, he said, *"reconfigures themselves emotionally a sense that they don't seem to get upset to any great extent"*. His evidence appears to have been directed towards situations of carers in institutional settings.

- 7.12 Noting that Grace was a person with a profound intellectual disability who, he said, had a *"very fractured experience of placement"*, Mr. McGovern referred to the fact that she had lived in at least three other placements before she came to Family X. This was at a fairly critical stage, he said, when a lot of bonding and attachment happened, and that was interrupted. He said that someone with a profound intellectual disability *"...cognitively, I don't think they are capable of the same type of attachment as someone who is functioning at a higher level"*.

- 7.13 Mr. McGovern's evidence was that, making an emotional investment in a relationship required a sense of knowledge of the other person external to them, whereas he observed that Grace had a limited cognitive ability. From what he had read and from his research, his view was that Grace's relationship with Mrs. X was one of dependency.

- 7.14 Mr. McGovern said that Mrs. X had a greater investment in Grace than Grace would have had in her. He drew this from a note that he had made at the time of his assessment of Grace in late 2008: *“Query: [Mrs. X] too attached to girl”*. Mr. McGovern said that, while he was relying substantially on his report when giving evidence, and could not recall very much, he had a sense of Mrs. X as being someone who seemed *“genuine enough, plausible and [who] seemed to have a degree of interest in her role as caretaker.”*
- 7.15 Mr. McGovern's view was that the type of relationship which Mrs. X would have had with Grace and which Grace enjoyed was more one of dependency, in terms of someone answering and anticipating her needs. He noted that:

“I suppose when we think of attachment we think of something which is reciprocal, which involves an emotional investment by the caretaker and also by the person who is being cared for. So, that is mutual, it is reciprocal and it develops over time. With someone who has a profound intellectual disability who has, in a sense, plateaued intellectually and they wouldn't have the same degree of investment emotionally in that type of relationship. So, I suppose, I'm talking about that in the broad sense, attachment is here.”

Managing transition

- 7.16 In his evidence on this issue, Mr. McGovern pointed to the fourth point of the “Summary and Conclusions” to his report, set out above at paragraph 7.8.
- 7.17 Mr. McGovern went on to say that, within the field of disability, normally speaking good practice was to have some kind of a graduated approach to someone who was moving from one facility to another or from their home of origin to a residential or group home. He said that, even when moving someone *“on campus”* in their own service from one group home to another, there tended to be some type of initiative to ease the transition process and that *“you do it in a sort of gradual and monitored way so it is not a shock and the person doesn't in some way suffer in the process”*. It was not some kind of random event that happened and he explained that *“you plan and ...you prepared the ground”*. He said that *“[o]bviously it is around understanding and it is around what they feel and sense as threatening or anxiety provoking, or whatever.”*

- 7.18 Mr. McGovern explained that respite was used as an initial measure as part of a graduated approach. It meant a stay away from what had been the person's regular home. Initially, the person would stay at weekends, go on outings and be involved in shared activities, and this would be tailored to the individual's needs. Mr. McGovern said that it meant that it "*desensitises*" the person so that the threat inherent in such a move would be removed. He described respite as a traditional phase in such planning.
- 7.19 Mr. McGovern's evidence was that the level of difficulty that Grace might encounter in making an adjustment was based on the manner in which the move was carried out. He said that good practice dictated that graduated steps needed to be carefully planned and carried out before the final phase, as opposed to a random or "*scattergun*" approach, adding: "*That is a prerequisite of any move, the transitional step [had] to happen first*".
- 7.20 Mr. McGovern noted that much of Grace's learning was based on conditioning or repetition. Her biological needs, such as toileting, sleep or other areas, tended to be programmed. It had taken years to build up simple skills incrementally, be they dressing, undressing, toileting, or other basic skills. Grace would respond more out of a sense of the day's routine. Mr. McGovern said that the move into alternative accommodation would have been similarly built up on a very incremental basis. In his evidence to the Commission, he said that, at the core of this, Grace needed in-built support, lots of structure and a lot of very intensive individualised help.
- 7.21 Mr. McGovern observed that there were unknowns about the effect of a move on Grace. He said that he would not have known what the benefit of socialising and being in the company of her own peer group would have been to somebody with Grace's level of disability. He noted her age and the fact that she had been living with Family X for many years and said that "[w]e *don't know when she steps over the threshold in a group home beyond her day service what the options are for potential living. So, we are opening up a sort of 'Pandora's box' in the sense we are not sure what she is stepping into.*" All in all, Mr. McGovern said that one would have to hope that it would be a positive move and to focus on the potential benefits.
- 7.22 Dr. Ferrari said she agreed with the "Summary and Conclusions" in Mr. McGovern's report, including the use of respite, which she said was normal and good practice. She said that she and Mr. McGovern both agreed that residential care should be

recommended and that it should be done “*according to good practice in a planned and gradual manner*”. She said that the suggestion made in the report for planning meetings sounded “*very reasonable*”, although she did not recall whether or not she had discussed that with Mr. McGovern at the time.

- 7.23 Dr. Ferrari said that, in terms of Grace’s profound intellectual disability, there would be some limitations in terms of the depth of attachment she could form but that, as a result of having Mrs. X as a primary caregiver for 20 years, there would have to be “*some emotional attachment or even some sense of continuity and routine and safety in having that*”. She emphasised that “[t]he 20 year relationship with Mrs. [X] would be something that I would think would be very relevant, very important ...for [Grace]”.
- 7.24 Dr. Ferrari said that minimising any negative effect of such a move was done by maintaining close contact with the caregiver and “[w]hether it be the mother or the foster mother, whoever is the primary caregiver, is very important. It would be extremely important to maintain that relationship. In the process of moving somebody from home to residential care it would be very important to keep that contact going and once the person is in residential care that contact should continue. [The process is] a very gradual process.”
- 7.25 Dr. Ferrari was asked during her evidence to the Commission whether, if there were adult protection concerns with respect to Grace, this would have affected her view on whether the move should have been gradual. In response, Dr. Ferrari said that if there were serious concerns that Grace was being mistreated, they would probably recommend that the move happen sooner rather than later, while still observing good practice by introducing Grace to the new placement and maintaining relationships as much as possible. She added that this would depend on the nature of the protection concerns identified.
- 7.26 The extent of what was conveyed by Mr. McGovern’s report to the HSE on the matter of Grace’s transitioning from her placement with Mrs. X to a residential setting was limited to the fourth point of his “Summary and Conclusions”, set out above at paragraph 7.8.

Findings

- 7.27 The Commission is satisfied, on the evidence, that Grace's dependency on Mrs. X was high. Mrs. X was not a temporary caregiver in an institutional setting, rather, she had been Grace's full-time primary caregiver from when Grace was 10 years of age until she was 30 years of age. It appears that this dependency was the basis of Grace's attachment to Mrs. X and also presumably to the home in which she lived for 20 years. The Commission is also satisfied that Mrs. X had an attachment to Grace.
- 7.28 Based on the evidence given by Mr. McGovern to the Commission, his view was that the process of managing a transition from Grace's home into a residential care setting entailed careful preparation. However, his 2008 report to the HSE did not reflect the detailed evidence given by him to the Commission on this issue. In his "Summary and Conclusions", he advised that he did not envisage that Grace would have any difficulty in making the transition to a group home, although he did note the use of respite to prepare her for eventual transition to such a home in his report.
- 7.29 The Commission has reported in detail on the management of Grace's case and the manner of her eventual move into residential care in Part 2 of Volume 1, Chapter 20. As reported, there were ultimately no transitional measures in place prior to Grace's move.

8. Early concerns about Grace's adjustment to the move

- 8.1 Following Grace's move into the residential placement, Ms D contacted Dr. Ferrari, Consultant Psychiatrist on 28th July, 2009 requesting that she see Grace and advise staff on how best to support Grace during her transition to the residential setting. This arose out of concerns about how Grace was adjusting to her move. Dr. Ferrari had had no involvement with Grace following her role in the assessment carried out by Mr. McGovern in 2008. Before the move occurred, she had not been consulted about any aspect of it.
- 8.2 Dr. Ferrari confirmed from her reading of contemporaneous notes that she had a discussion with staff and felt that, at that time, psychological rather than psychiatric intervention was required.
- 8.3 A month later, on 26th August, 2009, Ms B made a note that Grace was *"almost fully incontinent of urine and has also been incontinent of faeces and observed to smear faeces- also? refusing food regularly"*. She contacted Dr. Ferrari and noted that Dr.

Ferrari recommended that “[Grace] *has access to her previous carer as she [Grace] is displaying ‘classic signs’ of separation between her and [her] carer (previous)*”.

8.4 Dr. Ferrari was told that Grace’s behaviour was becoming increasingly disturbed and that the staff were concerned about her. Dr. Ferrari said in evidence that she would have felt that Mrs. X, having been Grace’s primary caregiver for 20 years, had *“obvious, very significant relevance to [Grace’s] life and a very acute separation, with no preparation and a total loss of contact, would cause emotional problems in [Grace].”*

8.5 Dr. Ferrari said in evidence that her belief at that time was that Grace was experiencing separation anxiety and needed to have contact with her previous foster mother. Grace’s behaviours indicated for Dr. Ferrari *“emotional upset, distress, disturbance”* which she agreed was *“consistent with”* a separation from her previous carer. Dr. Ferrari told the Commission that it is *“very hard to know exactly what causes everything in somebody with [Grace’s] level of, very low level of functioning”*; however, she thought that the most likely cause for the emotional disturbance was Grace’s separation from Mrs. X. The matters of separation and attachment, along with whether there should be ongoing contact between Mrs. X and Grace, are reported upon below at Section 11.

8.6 Dr. Ferrari said that her two concerns for Grace at the time were the fact that *“she had no further contact with her primary care giver for 20 years and the fact that she had been moved very suddenly with no preparation whatsoever into a totally different foreign environment.”*

8.7 The Commission is satisfied from the above evidence that the impact upon Grace of her move from her home into a residential placement and her separation from Mrs. X was an obvious concern at a very early stage following her move.

9. Grace’s presentation and behaviours – post July, 2009

Preliminary

9.1 The Commission heard evidence from two members of staff who worked in the residential placement concerning the severe deterioration in Grace’s behaviours and presentation that came on within weeks of her placement in this facility. These were

Ms R, who was a nurse, and Ms S, the Residential Services Manager. Neither of these members of staff had known Grace previously.

Ms R

9.2 Ms R is a registered nurse in the area of intellectual disability, having trained as a nurse in Cope Foundation in Cork. She worked there for two years before she left for the United States, where she worked with Volunteers of America, which was a school for two to five year olds with developmental delays. She subsequently changed jobs and took charge of a day care centre where she brought the service users out in the community and taught them how to work the subway system and buses. She did that for three years. She then worked for a private nursing agency before returning to Ireland. Ms R later became head nurse in a school for children with intellectual disabilities in Ireland before taking up her post in the residential unit of the local voluntary association in or around 2007. Ms R was the night nurse in charge when Grace was moved.

9.3 In her evidence to the Commission, Ms R said that she was “*absolutely horrified*” by the manner of Grace’s arrival to the unit. She said:

“...I thought ‘what is she doing here?’, and they said ‘it is an emergency case. She has to come in.’ And there was no preparation. There [were] four other girls in the house and nobody knew... nobody sat down and said ‘listen, you know, there is somebody joining ye’, or ‘she’s going to come in for a few hours, or she’s going to stay for half an hour initially.’ She was moved in lock, stock and barrel, and the other girls in the house weren’t given a choice in the matter...”

9.4 When she was asked to explain what would normally happen in a situation where somebody new came into the house, Ms R said:

“Well it is like anything. Your own child, you wouldn’t just drop your child off at the neighbours and say ‘he’s going to look after me’ You’d stay for a half an hour initially, or somebody would stay, or maybe – I just didn’t feel it was the right thing to do, to bring somebody into a house with four other people without – just arriving there... they should have been prepared that there was somebody going to arrive into their

[space]. *This was their home. Nobody does that...I don't arrive into your house and say 'oh, here's so and so, she's going to stay here forever', or we didn't know how long she was staying. We didn't know anything about her."*

- 9.5 Ms R's evidence was that the others in the house were introduced to the unit at six month intervals before going to live there. She qualified this to say that they were given about four months with the first person who took up residence in the house, and the other residents were brought in one at a time thereafter. She explained that:

"They all lived at home, all these girls lived at home. So it was fierce traumatic for the family, as you can imagine, even though the burden became excessive on the family, they were all getting elderly, so they came in and they'd come in for about four months and then the second service user would be introduced slowly, slowly".

- 9.6 Ms R said that two of the other residents in the unit could communicate verbally and the third resident could communicate well, albeit non-verbally. They had some high care needs. She said that she had a lot of information about the other residents and knew their families and everything about them. Ms R was very concerned that she knew nothing about Grace or her medical background. In the context of Grace's self-harming behaviours, for example, which sometimes resulted in bleeding, Ms R said that she was concerned as she was not aware of what, if any, medical condition Grace might have.

Grace's presentation on arrival

- 9.7 When Grace arrived first, Ms R said she was concerned for her physical appearance. She said that Grace was very dishevelled and that her teeth were in a very bad state. She said that Grace was not "*clean clean*" by any means. Her clothes were very old and "[e]verything looked second hand and not great". Ms R said, however, that this, in itself, was not a cause of concern for her, because she did not know where Grace came from. In this respect, Ms R observed that some parents did not really care too much about clothing. Recalling Grace's clothes, she said that they were not filthy but just old and were not folded. Ms R remarked that there was not "*much care in them*".

9.8 Ms R recalled that Grace's teeth were in a very bad state, that her breath was bad, and that her hair was not clean.

9.9 Remarking that she herself was not a psychologist, Ms R said that in the first day or two in her new placement, she thought that Grace was in shock and that:

"She didn't know where she was. She was totally disorientated...I just feel it was horrendous. Like she was suddenly after moving out of a house she was in for so many years and suddenly she's arrived into a new space and knew nobody. So I'd say she was anxious. Very anxious. A high stress level there".

9.10 Ms R said that, over a couple of weeks after Grace's arrival, her behaviour became "absolutely terrible". Ms R described this deterioration in Grace's behaviours graphically as follows:

"[s]he would hit herself off the walls...she would hit herself off the wall constantly, and there was blood all along the corridor, and the organisation said we should have a training session as to what to do. So we had a half-day training session with a behaviour[al] therapist and they said to put...a foam cushion against the wall when she banged her head...she'd move down very, very fast, so you'd get the cushion, put it against the wall, but by the time we'd done that she'd moved on. She kept moving because she didn't want – she wanted that physical thing in her head, she didn't want that barrier, the foam between her, something to do with that".

9.11 Ms D said that, if Grace could not hit her head off the wall, she went to the ground and then banged her knee or her hip or some other part of her body. As previously reported, Grace had a long-standing propensity to "head-bang" or to butt her head at times and in certain situations, such as at home, on the bus and in the day centre. The behaviours that Grace had exhibited from time to time over the years, have also been reported in Section 3 of Part A above, as well as in the First and Second Substantive Interim Reports and in Chapter 2 of this Volume. As reported in the First Substantive Interim Report and in Chapter 2 of this Volume, Grace was recorded as engaging in head banging as far back as before she was placed in foster care with Mrs. X in February, 1989. After that, head banging continued to be observed by Mrs.

X at home, by the manager and staff at Day Service Provider A, which Grace started to attend from 1995 onwards, and on the bus to and from Day Service Provider A. The Commission is satisfied, however, that the frequency, scale and intensity of this head-banging, as observed following her move in July, 2009, was noticeably on a different scale.

- 9.12 Ms R was not aware of Grace's history of head banging and self-injurious behaviours and she expressed in evidence the difficulty that this presented to her. Speaking of the incidents of Grace banging her head in a way that resulted in blood on the walls of the unit, she said that *"nobody deals with this without a history of the person and we didn't know anything about her and I was left out on a limb, it was not right."* Ms R said that she knew:

"Absolutely nothing. I'm quite angry about it, I hate to say. In all my years of working in organisations, to come in and to be told absolutely nothing about somebody. I didn't know what she liked. I didn't know what she liked to eat, what she liked to drink. I didn't know any of her medical history, which was baffling to me, especially that I was dealing with a lot of blood... I knew nothing about her. Absolutely nothing".

The question of "sexualised" behaviours

- 9.13 In the first weeks after the move, Ms B had a discussion with Ms R during which Ms R told her about some of Grace's behaviours that were causing her concern. Ms B described what Ms R told her in a note of a conversation with Mr. Smith in September, 2009, as follows:

"When first moved in; 'seize up' when drying intimate areas - is 'much better' now - 'more relaxed', but prefers to wash herself. If [staff nurse] fixes her duvet at night [Grace] is 'very startled'. Sleeps very far down in the bed, not using the pillow. On one occasion, [Grace] was getting ready for bed when [staff nurse] said 'get up go on the bed' (to get pad put on) [Grace] lay sideways on the bed, lower half of body off the bed, with legs lifted close to body, spread wide open."

- 9.14 With regard to her conversation with Ms B, Ms R said:

“Well I informed [Ms B] that – I worked with a lot of abused children...small children, not a lot but a few, and [Grace] definitely, when I went to give her a bath or tried to dry her, she was very, very squeamish... I just didn’t get a good sense when I tried to dry her or wash her in a personal area, and I had big concerns, and I went to [Ms B] and I said it to her that I had concerns that...something might have gone wrong in [Grace’s] life, and [Ms B] said to me she’d look into it.”

- 9.15 However, Ms R said that while she had an opinion, on a professional level, she would not make a call that somebody was abused or not.

Washing/drying intimate areas

- 9.16 With regard to her evidence about tending to Grace’s personal care, Ms R said that she thought that Grace was very uptight about any personal care or when she was being dried, going on to say: *“See, she really didn’t have the wherewithal to wash herself, she wouldn’t have had that, and she would have been doubly incontinent, so you’d really have to clean her especially, you know, you’d have to give her a good clean. So she would be very, she was very sensitive, uptight. Big issues with it”*. She said that Grace had no problems when she was drying her anywhere, but became quite tense when she was drying her intimate areas. Clearly, this reaction led Ms R to be concerned.
- 9.17 However, Ms R also agreed in the course of her evidence that it would not be unusual for a person to become startled if they were not used to some other person drying the intimate parts of their bodies. Ms D also said that, after a number of months, this lessened.
- 9.18 The Commission did not have evidence that Grace had been observed to act like this previously when she was assisted with her personal care in Day Service Provider A over the years prior to her move. In this regard, the Commission had evidence of Grace’s being bathed in the centre, trips to the swimming pool, and changes of her clothing associated with incontinence and of stripping off her clothing on occasion. There was also no evidence to the Commission to suggest that this behaviour had occurred in the care of Mrs. X. At the time that Ms R observed this concerning behaviour, Grace’s circumstances had changed entirely and she was showing significant signs of problems in adjusting to her new surroundings. Overnight, she

had gone from having her personal care attended to by her carer or in the day centre, to having that done in an unfamiliar setting by care staff with whom she was not familiar. The Commission considers that the possibility that such behaviour was related to the sudden and complete change in Grace's living circumstances or by unfamiliarity with a caregiver cannot be ruled out.

How Grace slept

9.19 As outlined above, Ms R also told Ms B that Grace slept very far down the bed and did not use a pillow. In her evidence, however, Ms R said that the way Grace slept in the bed, or her position in the bed, did not alarm her in any way and that she did not attribute sexual behaviour to this.

9.20 In relation to her observation that Grace became very startled when she fixed her duvet at night, Ms R was asked whether this could have arisen from the circumstances of being in a residential setting and of someone coming into her room at night. She said:

"I have to agree with you that I think – look, she was in a new setting. It was all so new to her. It was totally traumatic for her, I would imagine, and God knows I can imagine I would be startled too if I was just put in somewhere like that, I would imagine. Absolutely it could be just to do with the environment. It could have been an environmental thing, it could have been a high stress. I wouldn't read into that too much, because it was a big change for her moving to the house".

9.21 The Commission notes Ms R's evidence that she did not attribute anything sexual to the way that Grace lay in her bed or her behaviour on being disturbed during the night and the Commission is satisfied that this behaviour did not give rise to a concern that Grace had been sexually abused.

Changing Grace's pad

9.22 Ms R recalled that normally Grace was changed in the bathroom standing up. Ms R had a concern about an occasion when she was changing Grace's incontinence pad while Grace lay on the bed. She recalled in evidence that she was changing Grace and that she said to her, *"come on, we'll change you"*, whereupon Grace lay

sideways on the bed and “*spreadeagle[d] her legs*”. In evidence, Ms R described this as quite a sexual behaviour and thought it a “*very odd position for a young girl*” (Grace was 30 years of age at this time, but was often referred to as a child or girl). This incident occurred on one occasion. The Commission considers that this behaviour was so inextricably bound up with Grace’s responding to her incontinence wear being changed that it is difficult to identify it as a behaviour that could be viewed as having an underlying sexual cause.

Kissing

- 9.23 Ms R said that Grace used to push up against her and try to kiss her on the lips. She said that:

“... she’d try to kiss you, she’d try to kiss some of the girls, she’d try to kiss them on the lips. They were inappropriate. And she’d really hurt your back. She’d pull you in and she’d really try to nuzzle into you. So things like that she’d – and - or she’d if she caught your hand, she’d catch your hand gently first and then she’d catch it really strong where she’d actually hurt you”.

- 9.24 There was also an account from Ms B of similar type behaviour at a psychiatric appointment with Dr. Ferrari in July, 2010, the circumstances of which are considered when reporting upon the evidence of the medical witnesses below. As is reported there, Dr. Ferrari said that she “*never observed any behaviours in [Grace] that [she] thought were sexual or had a sexual motivation.*”

- 9.25 Some of these behaviours of pushing, grabbing and leaning into people reflected aspects of Grace’s behaviours as described over the years. These behaviours and possible connection to Grace’s sensory issues are considered further below.

Stripping

- 9.26 Ms R also recounted that Grace would strip every now and again and recalled an incident where she stripped and was trying to hit her head against the wall, and had to be administered *Valium* to calm her down. Grace’s behaviours got progressively worse throughout the end of 2009. Details with respect to treatments and medications required are reported below at paragraph 11.67. The Commission is not

satisfied on the evidence before it that Grace's stripping had an underlying sexual cause.

Gyrating

- 9.27 Ms R said that Grace would "gyrate" in the bath and in the bed. She said that *"it could go on for ages. I don't know if she was trying to get some kind of a satisfaction or something, I don't know what that was about"*. Surmising as to the cause, she said *"[m]aybe it was a comfort thing for her to go to sleep, I don't know."* Ms R recalled that Grace might not go to sleep for ages, saying: *"You could go into the bedroom and check on her and she'd be still looking at the light, not the light, but there was a little green light, you know for security, but she'd be just looking up at the light"*.
- 9.28 Mrs. X's evidence with respect to Grace's behaviour in the bath is reported above at paragraphs 3.28 to 3.31 in Section 3 of Part A.
- 9.29 Ms B also reported that Grace had gyrated against her leg and against a chair when she met with Dr. Ferrari in July 2010, reported upon below. Again, Dr. Ferrari told the Commission that she *"never observed any behaviours in [Grace] that [she] thought were sexual or had a sexual motivation."*
- 9.30 This aspect of Grace's behaviour is also referred to further below, when considering the evidence of Dr. Syed, who treated Grace after the move in July, 2009.
- 9.31 Ms R did not inform Dr. Syed of these behaviours but she did tell Ms B about them. She did not feel that it was something she would openly discuss with other staff members. In evidence, she said that *"on a professional level I wouldn't make a call that somebody was abused or not"*, so at a meeting with Dr. Syed she would not have brought that up.

Ms S, Residential Services Manager

- 9.32 Ms S qualified as a psychiatric nurse in Dublin in 1992. She returned to Waterford and worked in intellectual disability with the Brothers of Charity from 1992 to 2007. In 2007, she secured the post of Clinical Nurse Manager in the local voluntary association. Between 2004 and 2008 she obtained her BSc Honours Degree in

Nursing. Ms S worked in the local voluntary association as Clinical Nurse Manager from 2007 to 2014.

- 9.33 It was clear from the evidence of Ms S that she had concerns about whether Grace had been sexually abused, born not only out of suspicions as to what might have happened to have led to Grace's attendance at the Sexually Transmitted Infections Clinic and to her emergency admission to the residential unit, but also out of her own concerns about her behaviours.
- 9.34 Ms S had never met Grace and knew very little about her background at the time when she was placed in the residential unit. She said that they were given no records or handover with respect to Grace: *"We were told nothing. I suppose there was an air of secrecy about the whole issue"*. Ms S said that Grace arrived as an emergency admission and that there was little dissemination of information when she came in.
- 9.35 Ms S's initial impression of Grace was that *"she appeared to me like a little lost child"*. She said that Grace appeared unkempt and neglected when presented to the unit. She recalled that Grace's clothes were unkempt. She was untidy, as was her hair. Her teeth needed attention. Ms S described Grace as *"in general just unkempt looking"*.
- 9.36 Throughout the first few weeks, Ms S recalled that Grace presented with little or no challenging behaviour. Ms S said that it appeared that Grace was going to settle in. After that, however, there was a marked deterioration overall. Grace began to display self-injurious behaviour and it was very challenging in nature. Ms S was not aware of Grace's history of head-banging.
- 9.37 In describing this gradual deterioration of Grace's behaviours and the disturbed nature of her behaviours over a period of time following the move, Ms S recalled that Grace would strip off all her clothes and walk up and down the corridor. She said that she would *"walk anywhere. Generally towards the bath. But she could walk anywhere"*. It took a number of people to manage Grace in the residential unit.
- 9.38 Ms S said that while most of Grace's self-injurious behaviour, like banging her head off the corridor walls, happened during the night, it could happen during the day too. Grace would move along the corridor, strip naked, and bang her head off the walls to

the point of cutting herself. She was likely to bang any part of her body off the walls or furniture. Ms S recalled that *“it was quite intense”*.

- 9.39 Ms S also described Grace's tendency to *“lean in on service users and pinch them, grab them around the neck area and pinch them quite hard and lean in on staff members and it was very difficult to break away from that”*. She described it as a high stress time in the house.

The question of “sexualised” behaviours

- 9.40 Ms S said that she was concerned about every one of Grace's behaviours and the impact which they were having on the four other service users living in the unit and on the staff, itemising these as *“sexualised behaviours, defecating, smearing, incontinent of urine”*.
- 9.41 Ms S also observed, however, that *“because of [Grace's] degree of intellectual disability she displayed some sexual tendencies”*. Referring to the incident described by Ms R when putting on her incontinence pad, Ms S's evidence was that the way in which Grace exposed herself, while unacceptable, might have been acceptable for somebody of Grace's level of intellectual disability.
- 9.42 Ms S described an occasion when she pulled the elastic band of Grace's tracksuit pants to see if a pad was in place properly, causing Grace to jump. Ms S told the Commission that she considered this to be strange behaviour. She accepted that Grace might have got a fright, but she said that it was unusual.
- 9.43 As regards Grace's gyrating, Ms S said that *“somebody with such a severe profound intellectual disability that can, those type of behaviours can occur, at the same time there was a question mark over was she sexually abused”*. Ms S said that *“[t]hose behaviours for somebody with that level of intellectual disability were not strange”*. However, she also described them, as they related to Grace, as unusual.
- 9.44 Another incident that Ms S had relayed to Ms B was recorded by Ms B in the following manner:

“[Ms S] further reported that on the day [that Grace] went to hospital for dental treatment (26/8/09). [Grace] was lying on the table waiting

for general anaesthetic with pulse oximeter on her finger - [Ms S] reported that [Grace] moved hand to put oximeter between her legs + she moved her hand to stop her doing same. I queried whether [Grace] was itchy or didn't like having it on finger -? try it again- [Ms S] reported that she didn't".

- 9.45 Recalling this, Ms S said that she thought that Grace was *"aiming to go down to her private parts with the pulse oximeter on her finger"* and she thought that this was strange behaviour. Later, Ms S noted that *"I just thought it was unusual behaviour but then again not that unusual for somebody with that level of intellectual disability"*. She said that she had a query about it and also a concern in her mind that Grace might have been sexually abused. Ms S explained that *"I suppose all her behaviours were to [be] documented and that's what we did"*. She said that the instruction came from the top down and *"we were to document any behaviours and report anything, report all behaviours and anything unusual to [Ms B]. That's what we did collectively as a team."*
- 9.46 From her perspective, Ms S said that the concern as to whether Grace had been sexually abused arose from a combination of factors. There were concerns over her behaviours, and also there was *"grapevine"* information that there was a question mark being raised elsewhere as to whether she had been sexually abused. Ms S explained to the Commission that *"there was very little dissemination of knowledge to the staff in [the residential unit] myself when [Grace] did initially come in until I learned she had been to the STD Clinic"*. She said that this piece of information *"absolutely"* raised an alarm bell with her.
- 9.47 Ms S confirmed that the behaviours that she described witnessing or that were reported to her were behaviours that could be associated with somebody of profound intellectual disability; however, she said that contributing to her unease were her own observations and the fact of a concern circulating that Grace might have been sexually abused. Ms S agreed that she was not in a position one way or another to say whether or not Grace's behaviours evidenced prior sexual abuse; she was simply reporting what she observed. Ms S stressed that, *"I am not [a] psychologist. I am not [a] psychiatrist. I am [a] psychiatric nurse"* and *"I don't have those qualifications to determine what behaviour is correct and what behaviour is not correct for a person with that level of disability"*.

9.48 There was a difference in the evidence of Ms S and Ms R, on the one hand, and that of Ms D, on the other, with respect to whether Grace's file from the Day Service Provider A day service was available in the residential service when Grace was placed there. Ms D told the Commission that she believed that it would have been available, and that she believed *"that there was information shared, adequate information shared, initially on the admission, on the day of the admission. Also the following week that information was shared, but also that the file would have been available and that there was very good communication between the two services as well"*. Ms S, on the other hand, said that she did not remember receiving any file from Day Service Provider A in relation to Grace.

9.49 Regardless of this difference in the evidence about information flowing between Day Service Provider A and the residential unit, the Commission accepts the evidence of Ms S and Ms R that, when they were involved in Grace's care in the residential unit, their state of knowledge about Grace and her background was very limited.

10. Whether Grace's post-move behaviours signified past sexual abuse

Preliminary

10.1 The issue for the Commission concerning Grace's presentation and behaviours following her move in July, 2009 was whether these were signifiers of her having been subjected to sexual abuse. This issue was linked to the question of how this move had impacted upon Grace and the sharp deterioration in her mental health that occurred following the move. On the evidence available to the Commission, there was a stark contrast between how Grace was in herself before and after the move. The evidence established that, following the move, she was not fit to attend her day centre and was very unsettled, upset, agitated, unmanageable, and disturbed in her behaviours.

10.2 The evidence of Grace's medical team who treated her in the early years following her move was of fundamental importance on these issues. That team comprised Clinical Psychologist, Dr. Syed, and Dr. Ferrari, Consultant Psychiatrist, both of whom were employed by the Brothers of Charity.

10.3 At the time of giving evidence to the Commission, Dr. Syed was a Principal Clinical Psychologist with the Brothers of Charity. He completed a Masters Degree in Applied

Psychology in Pakistan before undertaking clinical training in the United States. Dr. Syed subsequently completed a PhD in University College Dublin. He was employed as a Principal Psychologist during the period that he treated Grace.

- 10.4 Dr. Ferrari studied medicine in University College Cork and graduated in 1980. She went on to do post-graduate training, initially in general practice, and then in psychiatry. She became a member of the Royal College of Psychiatrists in 1989. In 1992, Dr. Ferrari was appointed Consultant Psychiatrist in Waterford Regional Hospital. In 1997, she began working with the Brothers of Charity Services in the South East as Consultant Psychiatrist for adults with learning disability.

The medical evidence

- 10.5 On 26th August, 2009, a decision was taken to seek advice on Grace's case from Dr. Syed. He was unable to take the call and Dr. Ferrari was contacted instead. She advised that a psychologist should become involved. Dr. Syed was then tasked with helping to manage Grace's presentation and the behavioural issues facing the team in her residential unit.
- 10.6 A few months later, in October, 2009, following a meeting between the local voluntary association and the HSE, Ms B suggested to Dr. Syed that he should seek the input of Dr. Ferrari into Grace's case, having regard to Grace's worsening situation. Dr. Ferrari's involvement in the case, together with that of Dr. Syed, is reported below.

Information about Grace

- 10.7 On 31st August, 2009, Ms B wrote to Dr. Syed, providing him with background information on Grace in order to seek his advice on how best to support her in her transition into residential care.
- 10.8 On the question of Grace's behaviours she noted the following:

"[Grace] occasionally bangs her head on [the] walls and on the floor. It has also been noted since she commenced in our service, that she occasionally takes all of her clothes off. This has happened within the centre and also in public.

[Grace] always carries a set of plastic keys - she does not leave these out of her hand even when swimming, eating or sleeping, etc.

Before her move into residential care [Grace] was incontinent of urine at times, however, she would also use the toilet independently. Since her move into residential care [Grace] has become almost fully incontinent of urine, occasionally incontinent of faeces and has been smearing faeces, which she has never been observed to do before."

10.9 With respect to Grace's move into residential care, Ms B wrote as follows:

"[Grace's] move into residential care on 17/07/2009 was sudden and so there was no opportunity for a planned, phased introduction to the residential house & [to the local voluntary association] staff.

[Grace] arrived into [Day Service Provider A] as usual on the day of the move and, following a decision made by the Health Service Executive, she was transported to the residential house. She has not returned to her previous home or had contact with her previous carer since. [Grace's] previous carer has not requested to visit her.

[Grace] has attended day service as usual other than when she had an overnight stay in hospital for dental work on 26/8/2009.

According to her most recent psychological assessment (by Enda McGovern [in] October 2008) [Grace] is functioning at most within a 12 - 18 month developmental range. The report concludes that he does 'not envisage that [Grace] will have any difficulty making the transition to the group home as [he feels] her attachment to Mrs. [X] is not so significant that she will have any difficulty making that adjustment'. [Grace] appeared to settle in well initially and there have been no other behavioural issues other than those associated with toileting outlined above."

10.10 Dr. Syed was also given a copy of Mr. McGovern's assessment of Grace of October, 2008.

Dr. Syed meets with staff of local voluntary association

- 10.11 On 2nd September, 2009, Dr. Syed met with various members of the local voluntary association's staff, namely Ms C, its Director of Nursing, Ms B, Ms D, and Ms S. Dr. Syed was told about Grace's current behaviours in the residential unit. He was, by then, already aware of her self-injurious behaviour, her head banging, her problem with incontinence (urinary and faecal), issues with her appetite in the unit, and, referring to the wording of his own clinical notes, of her *"fixation with plastic keys and with staff"*. Dr. Syed also had the history set out in the letter from Ms B, referred to above.
- 10.12 Dr. Syed did not recall if he was told at that stage of Dr. Ferrari's view that Grace was displaying *"classic signs"* of separation from Mrs. X (see above at paragraph 8.3), although he could recall that the question of whether what they were seeing with Grace was the outcome of something experiential or emotional was something that they *"kept on discussing"*. He said that *"throughout when we were addressing the difficult phase in 2009 particularly and behaviours were very, very difficult to manage the ongoing discussion was whether this behavioural presentation is rooted in some experiential issue or an emotional issue. Sometimes it is neither of them, it is just the environment she was in that the environment was not catering for the need"*.

Dr. Syed and Dr. Ferrari meet with Mr. Smith

- 10.13 On 11th November, 2009, Dr. Syed and Dr. Ferrari (who had, by then, become involved in Grace's case in the manner outlined earlier) met with Mr. Smith. Dr. Syed said that they were told that the level of care from Family X had not been *"up to the mark"* and that a few areas had been neglected by Family X. He was aware at the time of this meeting of all the matters set out in a report prepared by Mr. Smith of November, 2009 (apart from the reference to the fracture to the little finger, an old injury). Dr. Syed was also aware of incidents of bruising, including the reference to the bruising in March, 2009. Although he did not know that Grace had been referred to the SATU on that occasion, he observed that the referral would have been information for him and that *"if it was positive it would have been an information for me and if it was negative it would have been an information for me"*. If there was no finding indicating sexual abuse *"[i]t would have been information that whatever the hypothesis was it was ruled out"*. It should be noted that the written report of the

SATU examination had not been obtained at that stage. The report, which did not find that sexual abuse had occurred, is dealt with above at Section 5 of Part A.

Possible sexual concerns

10.14 Dr. Syed said that behaviours that were related to possible sexual concerns were raised with him. He recalled concerns about Grace's kissing and touching people inappropriately, though he did not recall learning about the incident involving Grace's lying on the bed at the unit.

10.15 When Dr. Ferrari became involved in Grace's case at Dr. Syed's suggestion, Dr. Syed told her about the concerns that the local voluntary association's team had raised with him in November, 2009. In evidence, he referred to these as "*experiential and emotional*" issues. He said "*for example, there were, you know, doubts that she could have been, would have been abused*".

10.16 Dr. Syed said that there was no history of sexual abuse available to them and summed up the position as follows:

"..So that was the discussion that we don't have any information, so there are doubts, there [is] scepticism around that. Whenever we looked for information there was no information available to us. So this is what I would have talked to Dr. Ferrari about".

10.17 In his report dated 11th May, 2016, when referring to Grace's presentation after her move into residential care in 2009, Dr. Syed stated as follows:

"I tried to inquire about her history to ascertain if she passed through any psychological trauma. I was told that there is a question of some form of abuse in her previous residential placement, but there is no definite answer to that question. I kept on working without a clue of her past history and information related to any trauma. I suggested interventions to make her living and day service environment safe in her perception, to make them as anxiety free as possible. I was not provided with any information about any psychological trauma that is why I could not evolve any intervention to address any emotional or experiential aspect of [Grace's] presentation."

10.18 On the question of what Grace's apparently sexualised behaviour signified, Dr. Syed explained that:

"Generally when we see people like [Grace], who are severely or profoundly disabled, who are non-verbal, whose history is unknown, so we see many behaviours which look sexualised from the outset.... But as a matter of fact they are not sexualised as such. The reason would be anxiety. The reason would be some emotional issue, and many a times we have seen people, you know, being on the bed and making movement which look like, apparently it looked like a sexualised movement, but when we put the programme in place and we try to address some other issues, so those behaviours were addressed automatically."

10.19 He went on to say, *"So that, you know, gives me an idea that most of the time behaviour which may look like very sexualised in people with severe or profound level of disability....But it is not sexualised as such."* He also said, *"I have seen many people, as I said earlier, who were engaged in such a behaviour which was looking, apparently it was looking as if it is sexualised behaviour but the treatment we put in place was completely different"*.

10.20 In his 2016 report, under the heading "Assessment of Current Behavioural Presentation", Dr. Syed noted that Grace had previously engaged in inserting her fingers into bodily orifices and in excessive head-banging. He said that the former had not been evident for two years by then and that the latter had similarly reduced in frequency. With respect to those behaviours, Dr. Syed told the Commission that *"[i]t is not possible to describe one single definite concrete reason"* for them. He said that poking was a behaviour present in many people with intellectual disability that they treated, with no single reason for it.

Physical contact

10.21 In relation to Grace's desire for physical contact, Dr. Syed said that that behaviour was present before he started working with her. Even when staff were new, he said, she would try to have physical contact with them. Dr. Syed's evidence was that there were a number of reasons for this behaviour, not one in particular. He explained that a person with an intellectual disability, suffering from some attachment problems,

would do this a lot. In this regard, Dr. Syed said that some persons with an intellectual disability avoided physical contact, whereas others showed more need for physical touch or contact. Similarly, Dr. Syed observed that persons with sensory issues would sometimes avoid contact and, at other times, they would seek it out.

Sensory issues

- 10.22 Grace was described as a person with sensory processing difficulties, something which had been noted by Dr. Ferrari, Dr. Moran, and by Dr. Maura Haran, Senior Dental Surgeon, Special Needs with the HSE.
- 10.23 On 27th January, 2011, Dr. Ferrari wrote to Grace's general practitioner at the time recommending a sensory integration assessment for her in view of the fact that she appeared to have "*so many inappropriate sensory needs*". As mentioned above, Dr. Ferrari said that the constant forcefulness and pushing against people suggested to her that Grace might have some sensory problems and that something could be done about it.
- 10.24 In evidence, Dr. Ferrari explained that a sensory integration assessment was very complicated and was usually carried out by a physiotherapist who was specially trained in the area. She explained that a lot of people with intellectual disability had sensory problems in that they experienced sensations differently to the average person. Some people with intellectual disability, for instance, might need to be held tight or to wear tight clothing, giving a feeling of pressure on them, in order to feel calm and comfortable. They might be overly sensitive to noise and, therefore, would need a much quieter environment than the average person. Flashing lights or darkness might be very upsetting for them.
- 10.25 It appears that this sensory integration assessment was ultimately not carried out.
- 10.26 In a letter from Dr. Moran to Grace's general practitioner at that time on 22nd July, 2013, Dr. Moran observed that Grace "*clearly has sensory integration issues and clearly enjoys high pressure stimulation like hugging*". These sorts of maladaptive behaviours were well documented in the years before Grace was moved in July, 2009. In her report to Grace's general practitioner on 24th July, 2012, Dr. Moran noted that it was clear that Grace liked physical contact and that she habitually dug her nails into the back of her neck when she hugged her.

- 10.27 In a note for Grace's file dated 6th December, 2013, Dr. Moran noted that Grace *"uses pinching to communicate needs, and this is something better addressed by the team in a context of a psychological programme as medication is unlikely to eliminate this."*
- 10.28 In his 2016 report, Dr. Syed noted that, while Grace continued to engage in some aggressive behaviours, these had significantly reduced in intensity and frequency over the last number of years. He noted that Grace pushed, grabbed, pulled, or pinched others on a weekly basis, whereas previously those behaviours would have been seen hourly. Dr. Syed also noted in this report that Grace's behaviour of headbutting others had similarly decreased.
- 10.29 The treatment which Dr. Syed devised for Grace is reported on below. He said that with such treatment they saw an improvement in Grace. He emphasised that they never treated the behaviours described above as sexualised behaviours.

Devising a programme for Grace

- 10.30 Given Dr. Syed's lack of knowledge of Grace's past experiences, he thought that they should address her anxiety first. The approach adopted was to address the environmental changes in her life resulting from the move to residential care, on the assumption that the move itself was the underlying cause of her difficult presentation. This was combined with psychiatric intervention. That Grace ultimately responded to the programme put in place by Dr. Syed is reported upon further below.
- 10.31 The way Dr. Syed did this was through the application of the "Eidetic Growth Model". He explained that Eidetic theory proceeds on the basis that every experience, positive or negative, is stored in the mind and shapes personality. The model could be used to provide therapy for past negative experiences.

Eidetic Growth Model

- 10.32 The Eidetic Growth Model involved a therapeutic approach that, in Grace's case, focused upon her future experiences, in particular having regard to the anxiety she was displaying in her new environment. Dr. Syed explained that this was grounded in the fact that people developed images about their future experiences as well. He

had taken that principle and adapted it for persons who suffered from intellectual disabilities.

10.33 Dr. Syed said that the Eidetic Growth Model involved a two-pronged approach. The first dealt with emotional and experiential problems *“like attachment and emotional problem, abuse or trauma, experiential problem”*, the other with the current environment. According to Dr. Syed, the question to be addressed in treating Grace was *“how we are going to shape this environment, how we can reduce the anxiety, how we can prepare them for an upcoming event, how we can enhance their participation in meaningful activity through which they can learn something”*.

10.34 Dr. Syed explained that the aspect of how to shape the environment where people were working and where they were living was the fundamental point of the Eidetic Growth Model.

Application of the Eidetic Growth Model

10.35 Dr. Syed told the Commission that, if they had a clear history about any experiential problem in a case, they would try and deal with that. If they did not have any history, then they would go on to deal with the environment.

10.36 Dr. Syed explained that there were generally three elements when focusing on the environment in applying the Eidetic Growth Model. First, the environment should have activities that the person liked doing. Secondly, the whole environment should be made very predictable. Thirdly, if they knew that the individual was in conflict with the environment over something, they tried to remove or address the area of conflict. In that regard, Dr. Syed provided one small illustration of an environmental conflict for Grace where an obstacle was removed in this way. This was done by allowing her to have as many cups of tea as she liked, whenever she liked.

10.37 Dr. Syed referred to the experiential, the emotional, and the environmental as three layers of hypotheses when looking at treating behaviours in persons suffering from profound intellectual disability. He said that the first hypothesis with respect to persons, particularly those in the severe to profound range of intellectual disability, was that the behavioural issue was environmental. This was because such persons were non-verbal and unable to describe what might have happened to them and, because of that, how they felt and how they were behaving.

- 10.38 Dr. Syed explained that the first hypothesis he generally developed in his clinical work was to see if the person was having some form of stress and anxiety which might be coming from their current environment. This was because *“the current environment is the only environment which is there in our control where the variables can be manipulated we can [make] much-needed changes”*.
- 10.39 Dr. Syed said that the manifestation of anxiety and stress in people with severe to profound range of intellectual disability was generally through their behaviours. He said that those were the symptoms of the anxiety and the next step was to identify the reason for the anxiety. In this regard, Dr. Syed said that they would also try to make the environment very safe and secure so that the person felt and perceived their environment to be safe.
- 10.40 Dr. Syed told the Commission that he made the first hypothesis because nothing else was available to him. As noted above, he did not have any particular information, and was only able to speculate as to the existence of any experiential or emotional issue affecting Grace.
- 10.41 In implementing the Eidetic Growth model and putting a structure in place, Dr. Syed said that the overall aim was to make Grace’s new environment very predictable in order to try and deal with her anxiety. This work started in September, 2009.
- 10.42 At all times, the plan was for Grace to know what she would be doing next and with whom she would be doing it. The aim of this was to address her anxiety. This involved selecting activities of choice, communication about her timetable, and prior knowledge, which was intended to keep her informed of her routine, through the use of images. Having an element of variety in what she would be doing had to be eliminated from the plan because of her anxiety and her ability level.

Dr. Syed meets with local voluntary association staff

- 10.43 On 1st September, 2009, Dr. Syed had a meeting with Ms B, Ms C, Ms D, and Ms S where he recommended that Grace’s timetable should be the same each day. Dr. Syed was trying to make a predictable environment with as many activities of Grace’s choice as possible. He said that, where communication was an issue (Grace being non-verbal), a predictable routine needed to be set initially, so that the routine would then *“[communicate] to an individual automatically”*. A person would know from the

routine what was to come after “A” and what was to come after “B”. When the environment became predictable, over time it automatically addressed the anxiety coming from an unpredictable environment.

- 10.44 With time, and in combination with psychiatric treatment, Grace responded to the treatment programme that was put in place by Dr. Syed. In his 2016 report, he noted that “[i]n September 2010, [Grace] *had a relapse of psychotic conditions... After the relapse, we had to review intervention further to support her needs. Since September 2010 [Grace] showed a steady improvement.*” He noted results specifically in two areas: “[Grace] *looks far less anxious now. The behavioural presentation has been improved noticeably.*” He also noted that Grace’s “*participation has improved significantly both in terms of taking part in activities and in the level of engagement.*”
- 10.45 The extent of Grace’s mental health difficulties that occurred in the aftermath of her move in July, 2009 is reported upon further below. As Grace gradually responded to the regime of treatment, the extreme level of maladaptive behaviours and self-injurious behaviours that she exhibited following the move subsided. However, according to the evidence provided to the Commission, Grace continued to be susceptible to developing psychosis and remained on certain medications as late as 2016. Paragraph 11.67 below sets out the regimen which was put in place for her.

Findings

- 10.46 The concerns expressed by members of staff arising from their observation of certain behaviours of Grace, as reported above, clearly led them to worry about her and raised queries as to whether any of those behaviours indicated that she had previously been subjected to sexual abuse.
- 10.47 However, having regard to the totality of Dr. Syed’s evidence concerning Grace’s presentation and her behaviours considered above and bearing in mind the information he was given, the Commission is satisfied that he did not interpret those behaviours as evidencing or indicating that Grace had been subjected to previous sexual abuse.

11. Question of access to Mrs. X

- 11.1 References to “access” in this Section stem from the use of that word by witnesses and as encountered by the Commission in documents pertaining to the management of Grace’s case in the period shortly before and after her move in July, 2009. As pointed out in Volume 1, it was a term adopted without there being any evidence of any consideration by the HSE of its legal meaning within the context of family law and related proceedings. As a term, it is referred to throughout in the context in which it arose in discussions about, and decisions taken in, Grace’s case.
- 11.2 The question of whether Grace should have ongoing contact with Mrs. X arose for consideration by Dr. Syed and Dr. Ferrari as they looked for ways to manage the deterioration in her mental health following her move from Mrs. X’s. The move to the residential placement is reported upon in Chapter 20 of Part 2 of Volume 1.
- 11.3 Dr. Syed surmised during his evidence that contact between Grace and Mrs. X could have helped. However, he said that they had been told that, due to the HSE’s position, such contact was not possible or permissible. Dr. Syed said that, accordingly, he worked on the issues in the “*current environment*”.

Contact with Mrs. X in immediate aftermath of move

- 11.4 The first contact made with Mrs. X following Grace’s move was recorded in a note made by Ms Browne on Friday 17th July, 2009. On that date, she telephoned Mrs. X to tell her that Grace had been moved directly that morning from her day service to the residential placement. Ms Browne recorded that she asked if Mrs. X or her grandson would like to visit Grace over the weekend and that Mrs. X had said no. Ms Browne noted that she advised that if Mrs. X changed her mind, she could ring Day Service Provider A and make arrangements and informed her that Ms B would ring her on Monday to let her know how Grace was doing and to arrange a visit that following week if appropriate. She noted that Mrs. X asked if the bus driver had been informed and how she would get Grace’s clothes to her.
- 11.5 All that Mrs. X could remember in her evidence was being told that Grace had been moved by the HSE that morning and that her request to have Grace for two more weeks had been rejected. She could remember nothing about the reference to the suggestion that she could ring Day Service Provider A to make arrangements if she

wanted to visit Grace. The Commission is satisfied that what Mrs. X understood from this telephone call was that Grace was gone from her care and would not be coming back. It was clear from the evidence to the Commission that Mrs. X was upset by this news.

11.6 Ms Browne asked Ms B to telephone Mrs. X the following Monday and she advised Ms B that any visits would need to be supervised. A later note made by Ms Browne stated that *"[i]t was agreed that [Mrs. X] and/or her grandson [Alpha] would be facilitated to visit [Grace]. [Ms Browne] recommended that these visits would be supervised and that [Grace] should not leave [the residential unit]. It was agreed that if there were any attempts to move [Grace] that the Gardaí would be called."*

11.7 On Monday, 20th July, 2009, Ms B sent a message to Ms Browne to update her, as Ms Browne was out of the country on holidays. Her message stated that *"..everything is running smoothly. Rang [Mrs. X] her nephew said she 'took off suddenly' to stay [with] her sister 'up the road' because she was 'emotional'. He said he's not concerned for her state of mind. I will ring her again'. Advocate will send letter she feels move is in [Grace's] best interest & the reason why."*

Ms B writes to Mrs. X

11.8 On Tuesday, 21st July, 2009, Ms B wrote to Mrs. X. She said that she was hoping to speak with her to arrange transfer of Grace's belongings following her formal admission to residential services. Ms B said that she was aware that Mrs. X had discussed this with Ms Browne on 17th July, 2009 and that she had been told that she (Ms B) would make contact with her in order to arrange collection of Grace's personal effects. Ms B stated in her letter that they could arrange for Mrs. X to bring them to Grace herself, if she preferred. Ms B noted that Ms Browne had informed her that Mrs. X did not wish to visit Grace but that, should she change her mind, she could contact her (Ms B) in order to arrange a visit.

Ms B speaks to Mrs. X

11.9 Ms B telephoned Mrs. X again on 21st and 22nd July, 2009 and left a message with Mrs. X's nephew. She spoke with Mrs. X by telephone on 23rd and 24th July, 2009. Ms B synopsised these conversations in an email she sent to Ms C as follows:

"On Thursday 23rd July, I spoke with [Mrs. X] who stated that she was very upset, would consider visiting [Grace] 'in time'. She felt the HSE 'did it [the move] in the dirtiest way possible' and that [Day Service Provider A], was 'plotting' it for some time. I explained to [Mrs. X] that [the local voluntary association] merely facilitated the HSE in moving [Grace] at the request of her mother. [Mrs. X] did not ask how [Grace] had settled in etc.

I phoned [Mrs. X] the following day (Friday 24th). She again discussed visits and I re-iterated to [Mrs. X] that visits would be supervised, which she did not question. She stated that she was very concerned for her own financial position. I advised her to contact the citizens information centre & department of social welfare re pension entitlements."

11.10 In a further note dated 23rd July, 2009, Ms B recorded a telephone conversation with Mrs. X about Grace's move. Mrs. X indicated that she was *"not good"*. Ms B noted that Mrs. X said that she *"should have expected it, I'd been given lots of chances"*. Ms B also noted that Mrs. X said, *"I was happy [with Grace], [Grace] was happy with me, very happy"*. Ms B noted that she asked Mrs. X what she thought about Ms Browne's offer to visit Grace. She recorded that Mrs. X told her that she, Mrs. X, would not be able to *"walk away"* after visiting her, adding *"there's nothing I can do."*

11.11 On 27th July, 2009, Ms B sent a text message to Ms Browne to say that *"I have spoken with [Mrs. X] today and yesterday – did not ask after [Grace]. Is considering visits (she didn't question why the visits would be supervised). Doesn't seem to intend to challenge it. Today she asked how [Grace] is and is very concerned about her own financial position"*. When she was asked about the telephone call with Ms B at the Commission, and in particular the part of the note where Ms B recorded Mrs. X as saying that she would not be able to *"walk away"* if she were to visit Grace, Mrs. X said: *"That's right, I wouldn't, but I can't remember saying that to her."*

Offer of supervised access

11.12 When she was asked why she had never visited Grace or had any contact with her since she was moved in 2009, Mrs. X said that this was wrong and that she had telephoned Ms B and asked to see Grace and that Ms B had said *"you can't come*

until you're supervised". Mrs. X said that she asked "what did I do", and that Ms B had reiterated that "you can't come until you're supervised". When she was asked if this was the only conversation she had had with Ms B about going to see Grace, Mrs. X again said that "I rang her up and asked could I go see her. And she said, 'no, except when you're supervised.' I said, 'I done nothing.' She said, 'you can't see her until you're supervised. You can come if you're supervised'".

11.13 Mrs. X said at the Commission that she did not object to the idea of being supervised if she visited Grace. However, she went on to ask why she should be supervised, as she had not done anything. Mrs. X was asked if it would not have been worth being supervised if she could see Grace, to which she said: *"It would, but I hadn't the guts to go"*, adding *"not when I had to be supervised"*. Mrs. X also said that she had heard from a friend about how Grace was getting on, but she declined to give the name of this person in evidence and the Commission cannot be satisfied that this actually occurred.

11.14 Ms B said that her conversations with Mrs. X were quite matter of fact and that one of them was quite lengthy. She said that Mrs. X *"wasn't happy with how the move had occurred, obviously"*. Ms B said that Mrs. X was very angry with Day Service Provider A, although she said that this was not directed at her and that their conversation was not fraught in that sense. She also described Mrs. X as emotional on the telephone. Ms B said that she did not engage in the merits of the decision to move Grace or sympathise with Mrs. X during their conversation. Ms B also said that *"Mrs. [X] didn't express any, as I say, urgency to impart any information that she thought would help [Grace] to settle or to provide any personal effects"*. However, there was no evidence that the HSE or the residential placement had asked Mrs. X for any information about Grace at this stage, or at any time thereafter.

11.15 Ms B recalled that Mrs. X had said that she *"wouldn't be able to walk away if she came to visit [Grace]"* and that she would find it too hard to visit. Ms B went on to say, however, that, when they discussed visits, she recalled Mrs. X's saying that Grace *"would go with anyone"* and that Grace would not be *"bothered"* by that. Ms B said that what she thought Mrs. X meant by this was that Grace would not be bothered by not seeing herself or Alpha. Ms B took this to mean that *"[s]he seemed to just think [Grace] would go with anyone. She will be fine wherever she is and that she [Mrs. X] would find it too hard to visit"*. Ms B also said that she understood that, since Mrs. X did not question her with respect to supervision, she was happy to accept that any

visit would be supervised. However, it was not clear from the evidence to the Commission, reported above, that Mrs. X was entirely happy at the time with this proposed requirement.

Box of items delivered to Day Service Provider A

11.16 On 19th August, 2009, Ms B made a note that she had been informed by CW6 that a number of brown cardboard boxes had been left in the porch area of Day Service Provider A with Grace's name on each box. The boxes contained clothes and underwear, including thong-style underwear. Ms B noted that there was a strong odour coming from the clothes and that three garments were noticeably stained. In evidence, Ms B said that they were familiar with some of Grace's clothes, whereas others she had not seen before. They were a variety of sizes and in a variety of conditions. She recalled that some of the underwear was *"clearly newly purchased but opened"*. She noted that some of it was the wrong size for Grace. In that regard, she thought that some of the underwear was a size 14, whereas Grace was a size 6 to 8 at the time. When Ms B removed these items, they were clearly clean and had cardboard inserts in them, indicating that they had just been removed from their packaging. It was apparent that certain items of new clothing (in particular underwear) had been purchased for the box that was delivered, with a likely lack of proper attention to the particular purchases made. They had not been worn by anyone. Mrs. X could not give any evidence to the Commission on the return of these clothes, which had been dropped in on her behalf by Gamma.

Ms B updates Mr. Smith

11.17 Ms Browne and Mr. Smith and Ms B's manager, Ms C, were all on annual leave at the time of Grace's move into residential care. On 29th July, 2009, after Mr. Smith returned, Ms B updated him about events while he had been on leave. She told him how Ms Browne had suggested to Mrs. X that she and her grandson would be welcome to visit Grace in her placement, but that such visits would be supervised. Mr. Smith told Ms B that he was not in agreement with that for reasons that were not being communicated to the local voluntary association, based on information known to the HSE. Ms B's evidence was that it was agreed that the local voluntary association should write to the HSE seeking information, and setting out why it was required. She told the Commission that this was in relation to considering the

appropriateness of contact between Mrs. X and Grace and to assist in Grace's care plan.

11.18 In her evidence, Ms B noted that only two weeks previously, Grace had been living with Mrs. X, having been there for 20 years and said that *"...I suppose we were saying that it's quite a significant step to say that no contact, supervised or otherwise, would be allowed or that that wouldn't be a safe option for [Grace]"*.

11.19 This evidence was in contrast to a note prepared by Ms B on 26th August, 2009 that *"introducing [Mrs. X] into [Grace's] home would not be something I would advocate as I wanted [Grace's] new home to be safe and predictable for her."* Ms B said that that note was made after her conversation with Mr. Smith and that she understood that the information from the HSE at that time was that it was not safe to leave Mrs. X with Grace unsupervised. Ms B said that she had concerns about what the HSE apparently knew and what its concerns were regarding the question of risk to Grace from Mrs. X. She said the manner of Grace's removal on 17th July, 2009 also caused her concern.

11.20 It was on the above basis that Ms B was not advocating that Mrs. X be invited to visit Grace until they in the local voluntary association had a meeting with the HSE or clinicians. Ms B told the Commission that she was looking for a meeting where all of the information could be considered and discussed by those who were in a position to give a clinical opinion in areas such as psychology and psychiatry. Her hope was that a definite decision could be made as to what was in Grace's best interests and that they could then proceed with an appropriate invitation to Mrs. X, as decided by the clinicians.

Ms B speaks to Ms Browne

11.21 In her note dated 26th August, 2009, Ms B referenced two conversations with Ms Browne on the matter of contact between Mrs. X and Grace as follows:

"[Ms Browne] advised that they were agreeable to access - mother was not against same. Advised [Ms Browne] that in the meantime we would be seeking psychology intervention for [Grace] re same as access would not be possible at the moment."

"Return [telephone call] from [Ms Browne] - Advised that she had been speaking [with] [Mr.] Smith SWTL HSE and he was not advising access [with Mrs. X]. Due to his clinical experience, [Ms Browne] was happy to agree [with] same as HSE's position."

Mrs. X's reaction to Grace's move

11.22 Gamma gave evidence to the Commission of Mrs. X's reaction to Grace's move, saying *"she took it badly"*. Recalling these events of July, 2009, he said:

"Well they took her. What I recall is [Grace] went to [Day Service Provider A] as usual in the morning and that evening they took her from [Day Service Provider A], she didn't come home, they didn't tell [Mrs. X] they were taking her, they told her afterwards, that evening I think. She was very upset after that. I mean to say, you don't have somebody for 15, or whatever, odd years and to throw them away like a rag doll, as I say. We are a family, we are not like that".

11.23 Gamma told the Commission that *"[t]his whole thing I tell you has driven her to an early grave and we are very upset ourselves over it ..."*. He said that Mrs. X remained upset and that *"[s]he said she will go and see [Grace] when this is all over"*. He was visibly upset when giving this evidence to the Commission.

11.24 When he was asked what effect Grace's move into a residential setting in July, 2009 had on his grandmother at that time, Alpha also said that she was distraught and upset endlessly over the move, telling the Commission that *"I suppose it was a lost house without that one person in it"*. With respect to the weeks following Grace's departure, he said that Mrs. X was very upset over it and continued to be upset about it, adding that *"I don't think she ever really got over it, being honest..."*

11.25 The evidence established that Mrs. X did not make any further contact with Ms B or the residential placement to enquire if she could come to visit Grace. There was no further contact between Grace and Mrs. X after her move in July, 2009 other than the delivery of the box of items to Day Service Provider A, referred to at paragraph 11.16 above.

11.26 The evidence also established that no further contact was made at any stage on behalf of the HSE or the residential placement with Mrs. X on the question of visits to Grace, whether supervised or unsupervised. There were discussions on the topic of contact, as referred to below.

Discussion of contact - within the HSE

11.27 The issue of possible ongoing contact between Grace and Mrs. X arose for discussion at a number of HSE meetings concerning Grace after her move, namely on 2nd September and 20th October, 2009, which were attended by HSE officials and staff of the local voluntary association. The view of the HSE, in particular that of Mr. Smith, was that access should not be encouraged. The Commission is satisfied that Mr. Smith's view on this issue was born of his ongoing concerns about the placement with Mrs. X and his concerns for Grace, as reported upon earlier in this Chapter and in further detail in Volume 1. The above meetings are also reported in Volume 1 when reporting upon communications between HSE personnel and the local voluntary association at that time.

11.28 The meeting on 2nd September, 2009 was attended by Ms B, Ms C, Mr. Smith, and Ms Browne. One of the issues discussed was that of access visits. Ms Browne's note of the meeting recorded that she mentioned that Dr. Ferrari felt that access visits between Mrs. X and Grace should be encouraged. Mr. Smith disagreed with that suggestion. According to her note, no access was to be arranged "*at present*", and any request for access was to be "*discussed further and agreed in Care Plan.*"

11.29 On 20th October, 2009, there was another meeting about Grace attended by Mr. Pat Walsh, Acting General Manager of Waterford Community Care, Ms Browne, Mr. Smith, Ms B, and Ms C. On the issue of access, notes of the meeting made by Ms B stated:

"[Ms B] updated meeting re: [Grace's] recent presentation, behavioural programme devised by psychologist, difficulties adjusting to new environment, [query] sexualised behaviours.

[Ms Browne] queried separation anxiety, and Dr. Ferrari's recommendation re contact with previous carer. [Ms C] stated that we require any decision re same in writing from the HSE as there has

been a lack of clarity on this issue from the HSE and also given the lack of information available to [the local voluntary association] we are not in a position to give opinion re same.

[Mr. Smith] stated that he disputed Dr. Ferrari's recommendation and queried whether she was provided with relevant information in relation to [Grace's] previous placement prior to assessing [Grace] with Enda McGovern in October 2008.

[Ms Browne] stated that she had a 'full and frank' discussion with Dr. Ferrari about [Grace's] previous placement and, despite this, Dr. Ferrari maintained that there should be contact.

Meeting agreed that [Grace's] psychologist should discuss case with Dr. Ferrari and determine whether any psychiatric input required at the moment considering recent presentation...

[Mr. Smith] to speak with Dr. Ferrari to provide information, if she becomes involved in [Grace's] care."

11.30 Ms Browne disputed that she had used the term "*full and frank*" at the meeting. Dr. Ferrari could not recall the details of her discussion with Ms Browne. When giving evidence about her state of knowledge of Grace's case around this time, Dr. Ferrari told the Commission that recollecting this was "*really difficult and I have read so much now that sometimes I don't know whether what I think I know is because of all of the extracts I have been reading.*" She went on to indicate that she thought she was aware that there were more concerns about Grace's care in the previous foster placement by that stage, although she found it difficult to recollect what they were. Dr. Ferrari was aware that there were more concerns about the standard of care and that the social worker (Mr. Smith) was worried about her bedroom and whether it was really her bedroom or whether she was sleeping elsewhere. She was aware of the bruising leading to the hospital visit in March, 2009 and said that she might have known that there was some concern over Grace's finances or whether she had full use of her money.

11.31 A note of a Care Plan meeting on 5th October, 2009 attended by Ms B, Ms Caroline Burke, Independent Advocate with Waterford Independent Advocacy, Mr. Smith, Ms

D, Ms S, and CW13 recorded that “[Grace’s] *psychologist has not recommended contact - is focusing on addressing [Grace’s] anxiety first and then looking at the other complex issues in [Grace’s] life*”.

- 11.32 During his evidence, Dr. Syed explained that, at this time, Grace’s behavioural issues were quite severe and were not coming under control. He said that, for that reason, he suggested delaying contact at that stage, as he was trying to adjust Grace into her new environment. Dr. Syed said that he was then told that contact between Grace and Mrs. X was not possible in any event, given the HSE’s position on the matter. He explained that what they were trying to do was to adjust Grace to her current environment and that they had insufficient information about what could have been the possible reason for her behavioural presentation at that time.
- 11.33 At that juncture, Dr. Syed thought it advisable to keep Grace in one particular environment so that they could at least establish the environmental factor at that time, while leaving the two other factors, (emotional and experiential) for a later stage.
- 11.34 On 11th November, 2009, Dr. Syed and Dr. Ferrari recommended that, as Grace had lived with Family X for 20 years, there was still merit to her having contact with Mrs. X, under supervision, if there were concerns. Grace was still not good and her behaviours in the unit were fluctuating. At this time, Dr. Syed was of the view, as was Dr. Ferrari, that some contact with Grace’s former carer might be beneficial but, as already reported, the understanding was that contact was not possible from the HSE’s side. Dr. Syed’s treatment remained focused on addressing the current environmental factors for Grace. Dr. Ferrari’s views on contact are set out below in detail when reporting on her treatment of Grace.
- 11.35 Dr. Syed said that, in the light of his and Dr. Ferrari’s view that there should be contact between Mrs. X and Grace, he thought that there would have been an onus on the HSE or the local voluntary association to have taken active steps to arrange for this. In that regard, he pointed to an email which Ms B had sent to Mr. Smith on 13th November, 2009, and in which she had stated that, if the care planning team agreed that supervised contact would be of benefit to Grace, her view was that the local voluntary association should make every attempt to arrange and encourage such contact.

11.36 Dr. Ferrari did not know what efforts were made to try and establish contact between Mrs. X and Grace, but she said that she presumed that there had been some.

11.37 As reported above, the question of any further contact with Mrs. X was not pursued by the HSE and there was no contact from Mrs. X seeking to visit Grace.

Psychiatry - Dr. Nan Ferrari

11.38 As pointed out above, Dr. Ferrari's formal involvement with Grace in the context of her post-move behaviours commenced in October, 2009, when she was asked to conduct a mental capacity assessment for Grace. This was related to an application for wardship being prepared by the local voluntary association at that time.

Assessment 21st October, 2009

11.39 The assessment took place on 21st October, 2009. Ms B accompanied Grace. In her note of the meeting, Ms B recorded that Dr. Ferrari had told her that she had been given some information by Dr. Syed about Grace's placement of which she had not previously been aware. Ms B noted that:

"She said that the assessment conducted on [Grace] by her + Enda McGovern last Oct. [2008] was not done in the knowledge of this information - Also her recommendation re contact [with] previous carer was not made in the knowledge of such info and so should be 'taken off the table' pending further information being made available to her by the HSE. Requested [to] communicate same to HSE."

11.40 Dr. Syed said in evidence that he thought that he would have told Dr. Ferrari about concerns which the team in the local voluntary association had raised with him as to whether Grace had been sexually abused and about the lack of any history being available to them in that regard. As reported above at paragraph 10.16, he said that *"there was the discussion, that we don't have any information, so there are doubts, there [is] scepticism around that. Whenever we looked for information there was no information available to us. So this is what I would have talked to Dr. Ferrari about."* Dr. Ferrari did not recall her conversation with Ms B and did not have any recollection of a conversation with Dr. Syed where he gave her information of the kind referred to in Ms B's note.

11.41 Dr. Ferrari prepared a report on Grace following this assessment and noted that her “[m]ental state examination reveals no evidence of any formal Psychiatric Disorder, no evidence of a Depressive Disorder and no evidence of any significant Anxiety Disorder or Psychosis.”

11.42 In her evidence, Dr. Ferrari said that Grace’s behaviours at the time were a factor in an assessment as to whether or not there was an anxiety disorder, but that this anxiety could also occur when in distress, rather than as symptoms of an illness. The severity and intensity of Grace’s condition did not amount to a full psychiatric disorder at that time. Hence, Dr. Ferrari’s view was that any medical intervention at that time should be of a psychological rather than a psychiatric kind.

Assessment 11th November, 2009

11.43 Dr. Ferrari saw Grace again on 11th November, 2009. She felt that Grace was exhibiting signs of a psychiatric disorder and that she was possibly depressed as well. She was severely anxious. Dr. Ferrari recalled Grace’s being “*very disturbed*” and “*very agitated*”, “*unable to sit down*” and “*pushing around in the room*”, “*pushing against people*”, and “*very upset and distressed in herself*”. When Dr. Ferrari had seen Grace for the earlier assessment in October, 2009, Grace had sat quietly in the clinic. On this occasion, however, she said that Grace was unable to sit. Dr. Ferrari said that she was “*very, very disturbed*” on this visit.

11.44 On 13th November, 2009, Ms B emailed Ms Browne, copying Mr. Smith, Ms C, and Ms D, and told them of Dr. Ferrari’s recommendation that Grace should have “*some supervised contact with her previous carer*”. Mr. Smith replied to this email stating that “*my own view of the ‘access’ is that it is not an issue as Mrs. [X] has not responded to efforts to contact her and she has not taken up the offer that she can see [Grace] if she wants to under supervision. I feel that this is now unlikely.*”

Dr. Ferrari’s 2009 report

11.45 On 20th November, 2009, Dr. Ferrari wrote to Grace’s new general practitioner and reported as follows:

“As you know [Grace] is a 31 year old woman who functions in the range of profound intellectual disability.

[Grace] was recently removed from foster care placement by the HSE and was admitted to residential care with [the local voluntary association's] Services.

The transfer from foster care to residential care occurred rather suddenly in July of this year and [Grace] did not have the opportunity of being prepared for this major change in her life.

I was requested to review [Grace] urgently on 11.11.2009. [Grace] attended my clinic in Lisduggan Lodge accompanied by [Ms B], senior social worker, and another member of staff from her residential service.

Since the move to residential care, [Grace's] behaviour has become increasingly disturbed and despite psychological intervention her behaviour and mental state continue to deteriorate.

Currently, while [Grace] has no difficulty sleeping she appears to be distressed, anxious and agitated for much of her waking time.

More and more she is refusing to partake in activities. She demands tea throughout the day. If [Grace] doesn't get what she wants immediately, she engages in head banging. The head banging has been severe and has resulted in abrasion and bleeding to her forehead.

Staff also report that more and more [Grace] is refusing to have her meals and she has lost some weight in the last few weeks. Despite her distress [Grace] does not seem to cry. She is more inclined to laugh inappropriately when stressed. She never looks for affection.

While staff have implemented good regular structures to [Grace's] day, communication with [Grace] is very difficult. She is not particularly interested in using picture communication formats. She has very few Lámh signs and she has no speech.

She continues to attend her day service in [Day Service Provider A] as usual and staff report that her behaviour in the day service is not as disturbed as in the residential setting.

Of significance in [Grace's] history is the fact that she has no contact with her natural family who live [abroad]. Since early childhood, she has been in the care of the HSE and has had numerous foster care placements. [Grace] has lived with [Family X] in [location] from 1989 to July 2009. Since [Grace] moved to residential care she has had no contact at all with Mrs. [X], who would have been her primary care giver for a period of 20 years.

At assessment, [Grace] was distressed and anxious. She could not sit for any length of time. She wanted to get out of the interview room as soon as possible. She appeared quite miserable in herself. Examination however revealed no evidence of psychosis.

Psychiatric assessment in [Grace's] case revealed severe emotional disturbance with associated anxiety and possible depressive symptoms."

11.46 Dr. Ferrari's opinion and recommendations were as follows:

"In my opinion the severe emotional distress being experienced by [Grace] is secondary to having lost total contact with her foster mother of 20 years and her sudden move to a totally unfamiliar residential setting. While I am not certain that [Grace] is exhibiting definite depressive symptoms currently, I think she is at high risk of developing a severe depressive illness. She certainly shows signs of severe anxiety.

I have recommended that [Grace] be commenced on treatment with Efexor XL, initially at a dose of 37.5 mgs BD increasing gradually to 75 mgs BD.

I would also recommend that serious consideration is given to re-establishing contact between [Grace] and Mrs. [X] this could be done

on a supervised basis if there are any issues of concerns for [Grace's] safety.

I will review [Grace] again in a few weeks time."

Dr. Ferrari's 2010 report

11.47 In a report which Dr. Ferrari prepared for Ms Browne dated 20th January, 2010, she also stated that, in addition to the sudden loss of contact with Mrs. X, "[p]ossible past traumatic experiences could also be a factor" in the severe emotional stress being experienced by Grace. When she was asked if she could give a view on the relationship between those factors in terms of the cause of Grace's difficulty, she said that:

"I think at that stage I felt that the most likely cause for the deterioration in her mental state, because I knew that before her move to residential care she had been functioning fairly well in the day service...very soon after the move to residential care, her mental state deteriorated, her behaviour deteriorated and she became extremely distressed. My opinion was the sudden move without time for preparation...The sudden move without preparation, the loss of contact with her primary caregiver would have been the main factors contributing to the deterioration in the mental state, her mental health."

11.48 With respect to the recommendation on contact contained in her 2009 report, Dr. Ferrari told the Commission that, if there were concerns for a person's safety, then it was appropriate to do supervised visits, so that was her recommendation. Part of her thinking, she said, was that Mrs. X was quite old and, if there were safety concerns, she could not see how much risk Mrs. X could pose to Grace at her age. In short, she said that if visits were supervised, she did not see them presenting any safety risk.

11.49 The Commission is satisfied that Dr. Ferrari was very concerned about the impact on Grace of her move into a totally unfamiliar residential setting and of the sudden total loss of contact with her carer of 20 years. This feature was emphasised in both her 2009 and 2010 reports.

Care planning meeting

11.50 On 7th December, 2009, a care planning meeting took place about Grace, the minutes of which reiterated Dr. Ferrari's position with respect to the matter of Grace's having contact with Mrs. X. In this regard, the minutes read:

"regardless of the relationship between [Grace] and her previous carer, [Dr. Ferrari] would recommend contact be encouraged due to the emotional trauma that the sudden removal of contact with [Mrs. X appeared] to have caused."

11.51 The minutes also noted that Mr. Smith stated that:

"he doesn't agree and referred to the team's discussion in the previous care planning meeting where it was highlighted that when [Grace] first attended [Day Service Provider A] she presented with some similar difficulties. [Mr. Smith] therefore considers that this presentation is an indication of [Grace's] adapting to change. [Mr. Smith] intends to reply to Dr. Ferrari in relation to these issues and advise that he is not in agreement that there should be contact between [Grace] and her previous carer".

11.52 Grace's difficulty in adapting to change was a matter well known to the HSE for many years at this stage. Referring to the impact of change in circumstances for Grace, Dr. Ferrari noted in her evidence that, when she was admitted to the day service in 1995, she was not referred to psychiatry because, even though her behaviour was disturbed, she was not as severely distressed as she was after her admission to residential care. Dr. Ferrari said that there would have been a big difference in the intensity and severity of Grace's distress in presentation *"which means to me that...the removal of her primary carer from her life had a significant effect"*.

11.53 Dr. Ferrari remarked that Mr. Smith was implying that the only cause of Grace's distress was the fact that she was in a different environment. However, she maintained that the fact that Grace had been separated from her primary carer of 20 years had as much of an adverse impact on Grace. Mr. Smith did not have an independent recollection of this meeting at the Commission. He did not remember

discussing Dr. Ferrari's recommendation for access, as referred to in her letter to Grace's new general practitioner (which had been copied to him).

- 11.54 Dr. Ferrari could not recall if she was aware at the time of the apparent concern in the HSE that, at the time of the move, Mrs. X might do something unwise (or that Grace might be unmonitored during the time that Day Service Provider A was closed for holidays). This concern is reported on in Chapter 20 of Part 2 of Volume 1. However, she said that, *"even if I knew that, I would still be recommending some contact supervised with Mrs. [X]... because I really felt that that was extremely important for [Grace]"*. As referred to above, she said that *"[i]f the visit was supervised, Mrs. [X] is an old lady, it would be very unlikely in a supervised visit that she could hurt [Grace]"*. It is important to note that there was no evidence that Mrs. X had made any threats about taking any steps to harm Grace or indeed any actual threats to harm herself at that time, nor did she ever actually do so.

Interpretations of Grace's behaviour

- 11.55 The differing interpretations placed on how Grace behaved at this time was illustrated by her appointment with Dr. Ferrari on 28th July, 2010. This was apparent from a report about the visit which Ms B included in a letter to Dr. Caffrey dated 29th July, 2010, in which she set out various behaviours of Grace for the purpose of his psychosexual assessment of Grace.

- 11.56 In this report, Ms B recounted that, when she and Ms D had brought Grace to the appointment with Dr. Ferrari, she had observed Grace to lean in on top of Dr. Ferrari. Ms B wrote that, while this was typical of Grace's recent presentation, on that occasion, Grace had leant over the arm of Dr. Ferrari's chair and appeared to be seeking clitoral stimulation by rubbing herself against the chair's edge. Ms B reported that Grace had later gyrated against the chair, leant against Ms D and gyrated against her leg, and also attempted to kiss Ms D on the lips.

- 11.57 Dr. Ferrari said that, while she did not recall the specific appointment, she had:

"never observed any behaviours in [Grace] that [she] thought were sexual or had a sexual motivation... Certainly I would have observed her on many occasions to be very forceful and pushing against people. She would push against people and she would

come up to me and push against me, push against my chair, push against the staff. Sometimes the staff had to come and remove her from me because she was pushing, she would push so hard. But I never attributed a sexual motive to any of that forceful physical behaviour... So I obviously didn't here. I haven't mentioned it in the notes..."

- 11.58 Dr. Ferrari said that she had not mentioned Grace's behaviours at that clinic probably because they were the same as her usual behaviour at it. She said that, if she had noticed Grace being sexual, she would have put it in the notes to Grace's general practitioner. There is no reason to doubt that this was the case and the Commission is satisfied that while Ms B was concerned about Grace's behaviour, it was not behaviour to which Dr. Ferrari, as Grace's psychiatrist, attributed a sexual motivation.
- 11.59 Dr. Ferrari recalled being told about concerns regarding Grace's bowels and that this was being discussed as being a possible proof of sexual abuse. She recalled that Mr. Smith was raising those points at a meeting to indicate that he believed that Grace could have been sexually abused and that that was something with which she disagreed. She said that *"[i]n my opinion a lot, a substantial number of people with intellectual disability have bowel problems and especially if they are on psychiatric medications. So, I disagreed with that assessment"*. She said that she certainly could not take Grace's bowel problem as an indication of sexual abuse having occurred, nor the concern regarding what was Grace's bedroom. Therefore, as far as she recalled, she did not have any information that would have led her to think that Grace could have been sexually abused at some stage.
- 11.60 There was no objective evidence whatsoever, medical or otherwise, to the Commission to link any issue that Grace had with her bowel at this time to possible sexual abuse. The origin of Mr. Smith's concerns on this matter derived from what had been relayed to him by Mrs. Z about her conversations with a consultant gastroenterologist concerning her daughter's bowel issues, which led Mr. Smith to believe that she had been told that those problems were connected to sexual abuse. It suffices to report for the purposes of this Chapter that the Commission investigated this matter and found that what had been relayed by Mrs. Z to Mr. Smith on this aspect, was fundamentally incorrect. This matter, and Mr. Smith's inclusion of his contact with Mrs. Z in his March, 2008 report, is reported in Part 1 of Volume 1. Mr. Smith's report had also referred to another individual with a bowel problem, namely

rectal bleeding, the cause of which was not known. Mr. Smith understood, at that stage, that that individual had stayed with Family X for a short period in 1989. However, when contacted by An Garda Síochána in November, 2013 in the course of the Garda investigations, neither the individual nor his family had a recollection of his staying there and there was no complaint made.

- 11.61 Mr. Smith recalled that he had met Dr. Ferrari at some point. He could not remember what he had told her about concerns of sexual abuse, but he told the Commission that he could have said that he had adult protection concerns regarding physical abuse, neglect and possible sexual abuse, although he would not have specifically identified any other service users. As noted above, Dr. Ferrari was aware that Mr. Smith had adult protection concerns for Grace, although she had, at best, only limited knowledge or detail of any concerns relating to other service users.

Significance or otherwise of behaviours to query of sexual abuse

- 11.62 Dr. Ferrari's view at the Commission concerning the nature of Grace's behaviours and what, if anything, they could be taken to signify, was substantially the same as that of Dr. Syed's. In this regard, Dr. Ferrari's evidence was that she never observed any behaviour in Grace that she thought was sexual or had a sexual motivation. She did not regard Grace's behaviours as indicating that she had been sexually abused. Rather, Dr. Ferrari was concerned throughout about the impact that the move and separation from her previous carer had had on Grace's mental well-being.

Finding

- 11.63 Having regard to the totality of Dr. Ferrari's evidence concerning Grace's presentation and her behaviours, considered above, the Commission is satisfied that she did not interpret those behaviours as evidencing or indicating that Grace had previously been subjected to sexual abuse.

Impact of decline of Grace's mental health

- 11.64 The Commission is satisfied on the evidence with respect to Grace's presentation, that the impact on her of the move into residential care was profound. The psychiatric condition developed by Grace following her move was severe. There was no evidence to the Commission that she had previously suffered mental health

difficulties of a psychiatric nature, and the difficulties that she faced at this time were new to her. In that regard, it is appropriate to observe that, notwithstanding her profound intellectual disability, Grace had been a person who was generally observed to be in good health. She had not required medication or any other intervention, associated with her mental health, arising from any assessment or medical examination, at any time before her move into residential care in July, 2009.

- 11.65 The picture that emerged from the evidence about Grace's presentation and her medical regime from this time, was in sharp contrast to the overall picture of her life before her move, as reported in the chapters of this Volume and in the Commission's previous substantive reports. After her move into residential care in July, 2009, Grace's mental health declined steeply and she required a very high level of day-to-day supervision and care.
- 11.66 The evidence to the Commission disclosed the extent of Grace's mental health difficulties that occurred over the period following her move in July, 2009. The medical records and evidence provided to the Commission disclosed that, in the months following the move, Grace developed psychosis, severe anxiety, agitation, restlessness, depression, emotional disturbance, changes to appetite, double incontinence, sleep disturbance, weight gain, drooling, gastrointestinal problems and bloating, postural problems, and extreme stress-related symptoms. At times, Grace was reported to have engaged in excessive self-injurious behaviours and to have been physically forceful with staff and other service users in the residence. In September, 2010, she was moved into self-contained accommodation, a less stimulating environment for her, in order to prevent other service users being adversely affected by her behaviour.
- 11.67 Medications prescribed in the treatment of Grace during this difficult period included *Zyprexa* (an anti-psychotic medication), *Diazepam* (a medication used to treat anxiety), *Efexor* (an antidepressant medication), *Lexapro* (an antidepressant medication), *Anxicalm* (a medication used to treat anxiety), *Zispin* (an antidepressant medication), *Risperidone* (an antipsychotic medication), *Dalmane* (a medication used to treat insomnia symptoms), *Akineton* (a medication used to treat Parkinson's disease and certain drug-induced movement disorders), and also *Lamictal* (a mood stabiliser medication). Grace also suffered side effects of some medications.

11.68 As a result of all of the above, Grace required close monitoring and high supervision in her placement. She was seen regularly for review during this time by a psychiatrist¹⁰ and the behavioural management programme with Dr. Syed continued to be implemented. As conveyed by Dr. Syed in his report of 11th May, 2016, Grace's condition gradually improved and settled down somewhat, although she continued on certain medications.

Dr. Moran, Consultant Psychiatrist

11.69 The Commission also considered the evidence of Dr. Moran, Consultant Psychiatrist, who had prepared a report with respect to Grace in 2016 for the purpose of the High Court proceedings taken against the HSE on behalf of Grace by her Committee in Wardship. Considered below, in particular, is the aspect of Dr. Moran's report referring to the question of sexual abuse and her evidence on the preparation of her report.

11.70 Grace had come under the care of Dr. Moran in June 2012, when Dr. Moran worked with the Brothers of Charity. She was Grace's treating psychiatrist until 2016. Dr. Moran is a Consultant Psychiatrist, a Consultant General Adult and Community Psychiatrist, and a cognitive behavioural psychotherapist. At the time of her evidence, Dr. Moran was registered in Psychiatry of Learning Disability and was an Honorary Senior Lecturer with the Royal College of Surgeons in Ireland, a serving member of the Irish Medical Council, an expert panel member for the Mental Health Commission, and also a medical visitor for the High Court for the purposes of wardship.

11.71 Dr. Moran met with Ms B and Ms D on 8th March, 2016, when Grace was brought to her for a review. This was for the purpose of providing Dr. Moran with relevant information for her report. Ms B provided information to Dr. Moran at this meeting.

11.72 Dr. Moran's extensive notes made at this meeting, based on the information conveyed to her by Ms B, included reference to the previous allegations (these were the allegations set out at Section 1 of Part A above), the events in 1996 (reported on in the First Substantive Interim Report), Grace's lack of attendance at the day placement, the two hospital visits in 2008 and 2009, and assertions of neglect/abuse,

¹⁰ Grace was last seen by Dr. Ferrari in September, 2010, after which Dr. Ferrari retired. Grace came under the care of Dr. Nicholas Corrigan from December, 2011 to March, 2012 and of Dr. Maeve Moran from June, 2012.

isolation, and poor hygiene. These notes detailed all of the concerns in Grace's case as conveyed to her by Ms B.

- 11.73 After the meeting, Dr. Moran wrote to Ms B, asking her to send on all the information that she had on Grace. Dr. Moran said that she did not get more written information. However, as reported below, she subsequently spoke to Ms B after she had prepared her draft report.

Preparation of Dr. Moran's report

Draft report and final report

- 11.74 Dr. Moran initially prepared a draft report and, thereafter, her final report. Insofar as the question of sexual abuse was concerned, her final report, unlike the preceding draft, proceeded on the basis that Grace had been sexually abused. The basis upon which that occurred is reported below.

- 11.75 The general background information upon which Dr. Moran's draft was based derived from having met with Grace on one occasion for the purpose of the preparation of the report, from what she had learnt when acting as Grace's consultant psychiatrist since 2012 and from notes on her file, from what she had been told at the aforementioned meeting in March, 2016, and from a social worker report from Ms B, which reflected the history and concerns as discussed at the meeting.

- 11.76 Dr. Moran shared the draft of her report with Ms B. Dr. Moran said that she then received further information from Ms B that, in the context of High Court proceedings taken on behalf of Grace by the General Solicitor, as her Committee, against the HSE, *"the HSE had withdrawn their denial in relation to [the allegation of] sexual abuse of [Grace]. That was the further collateral information I had from [Ms. B] between the two reports."*

- 11.77 The circumstances in which that denial came to be withdrawn by the HSE is reported upon at paragraph 11.86 *et seq.* below.

- 11.78 On the basis of the information she obtained from Ms B, Dr. Moran made amendments to her draft report on the question of whether it could now be stated that Grace had actually suffered sexual abuse.

11.79 Dr. Moran's draft report had stated the following:

"[Grace] is a young lady with a profound intellectual disability who has suffered significant trauma in her past, I am unaware of the detail of this trauma. In addition her move to residential care occurred without any opportunity for [Grace] to be prepared and, as such, had a profound impact on her mental state" (emphasis added).

11.80 However, in her final report, Dr. Moran stated that:

"[Grace] is a young lady with a profound intellectual disability who has suffered significant trauma in her past. I am aware this trauma included sexual abuse. This trauma was compounded by her move to residential care without an opportunity for [Grace] to be prepared and as such had a profound impact in my opinion on her mental state" (emphasis added).

11.81 Dr. Moran's draft report had also stated: "My opinion is limited by the fact that I do not have the detail of HSE's concerns in relation to alleged sexual abuse in [Grace's] case". Her final report stated instead: "My opinion is limited by the fact that I do not have the detail of the sexual abuse in [Grace's] case."

11.82 On the question of post-traumatic stress disorder, Dr. Moran told the Commission that she was already considering this arising from the meeting in March, 2016, at which she had been told more about Grace's care before she went into the residential placement. She said that "[i]n my clinical opinion, borne out by knowing her over eight years and seeing her and being her treating consultant to this day, she definitely has post-traumatic stress disorder irrespective".

11.83 In this regard, Dr. Moran observed that, moving from a familiar setting to a totally new setting could cause post-traumatic stress disorder in someone with a profound intellectual disability. She said that this was the case even if a person was coming from an abusive setting. She told the Commission that:

“I was considering post-traumatic stress disorder and I put it in my final report when I felt that I had all the information that I was going to get in the context of social history. But it's not necessary to have even been physically, you know, in someone with a profound intellectual disability, simply moving from one setting you are very familiar with precipitously to another could trigger that”.

- 11.84 On her understanding that past sexual abuse had been established, in her final report, Dr. Moran reported as follows:

“History of Post-Traumatic Stress Disorder likely in relation to sexual abuse.

In relation to the sexual abuse in people with intellectual disability, although they cannot communicate their distress the way that someone with good verbal skills can, it is possible to ascertain from their behaviour that they are distressed and there is no doubt that [Grace] was psychologically distressed both in her initial attendance in the day services in [the local voluntary association] and also at the rapid transfer to residential care. I think it isn't unreasonable to conclude that she was suffering from psychological distress; likely related to profound failures in her care setting.

In my opinion having suffered failures of care in her care setting hampered her ability to grow, to learn social skills and her ability to learn new things, as it is likely that she was overwhelmed by anxiety, hypervigilance, sadness in a setting where she wasn't receiving adequate care without any interventions for many years.”

- 11.85 Dr. Moran also reported that Grace had a reactive attachment disorder, namely what she described as a *“consistent pattern of inhibited emotionally withdrawn behaviour toward adult care givers, in that [Grace] rarely seeks comfort when distressed appropriately or responds to comfort when distressed.”* During her evidence, she outlined her professional view as to how this arose, noting that:

“... it's common among, sadly among many adults with intellectual disability who have a number of different caregivers. It is an issue for [Grace] to this day, they insecurely attach to caregivers. So, to this day [Grace], for most of us if we are lucky enough to have a stable environment between the ages of zero and three, we securely attach to people. What that means is we are able to tolerate other people's [disapproval] without feeling upset or traumatised by it. We have a secure sense of self. We are okay if people we care about choose to spend time with other people. In [Grace's] case [Grace] insecurely attaches. So, what [this] means is that she bonds with a caregiver and she to this day can become dis-regulated and anxious if that caregiver's attention is directed elsewhere.

So, constancy in the people who support her, it's like a corrective emotional experience. This is true for adults without intellectual disability as well. It never fixes that lack, if you like, and some of that, those attachment issues pre-date [Grace's] placement in the South Eastern Health Board, obviously from her history. So, I thought it was important to add that in because anxiety will be triggered. [Grace] can't communicate verbally and if she has a whole load of different staff supporting her, agency staff, locum staff, that could then present itself as self-injurious behaviour, dis-regulation, et cetera. There is a concept in diagnosing psychiatric illness in people with intellectual disability called diagnostic overshadowing where because of the person's intellectual disability, sometimes things are attributed to disability that are, in fact, psychiatric illness. That is why collateral information in addition to serial assessment but especially collateral information is so important”.

Withdrawal of plea in HSE's defence

11.86 As reported at Part 5 of Chapter 1 of the First Substantive Interim Report, the HSE's defence to the proceedings taken against it on behalf of Grace had conceded liability but denied that she had been “*sexually abused by her foster carers and/or by others while in their care over a number of years as alleged or at all.*” The HSE subsequently amended its defence to withdraw that denial, before entering into a

settlement of the proceedings. It is important to note that the “*foster carers and/or... others*” were not parties to the proceedings and that there had been no investigation by the HSE at that stage.¹¹

11.87 The Commission, pursuant to its Terms of Reference, is mandated to conduct an investigation of whether Grace suffered any sexual abuse during her time with Family X. When making its own findings on that matter, the Commission is satisfied that the question of whether or not Grace had been subjected to sexual abuse had not been established as a matter of fact at the time of the HSE’s decision to withdraw the aforementioned denial in its defence.

11.88 With regard to the above, the First Substantive Interim Report also refers to apologies which the HSE made to Grace and her mother in January, 2016, both of which referred to Grace’s having suffered “abuse” during her time with Family X. Appendix 1 to that report contains correspondence between the Commission and the HSE in relation to this matter. As can be seen from that, the Commission had queried with the HSE the precise nature of the “abuse” (as defined in its Terms of Reference, which includes sexual abuse) for which that apology was made. In response, the HSE listed a number of instances of reported injuries to Grace from the Devine Report¹² and which the HSE said gave cause for concern. The Commission then asked the HSE if it had concluded that they arose as a result of physical abuse perpetrated upon Grace. The HSE replied in the negative, stating that the apology issued “*following a review of the totality of the Devine and Resilience Reports and in circumstances when extracts of those [Reports] were to be published. Those Reports identified failings on behalf of the HSE/SEHB and the apology was issued in that context and written corporately on behalf of the HSE.*”¹³ These, along with other allegations, are yet to be investigated by the Commission.

Findings

11.89 It was clear from Dr. Moran’s evidence that, when she was preparing her draft report, her opinion on Grace was limited by the fact that she did not have any detail about the HSE’s concern in relation to alleged sexual abuse of her. When Dr. Moran was subsequently advised by Ms B that the HSE had withdrawn its denial of the allegation

¹¹ The proceedings were initiated on 22nd July, 2014. A defence was delivered on 16th October, 2014. An amended defence was delivered on 13th June, 2016.

¹² Report of Conal Devine & Associates Inquiry into Protected Disclosures, SU1 (2012).

¹³ Report of Resilience Ireland Ltd. Disability Foster Care Report HSE South East (2015).

of sexual abuse made in the High Court proceedings taken on behalf of Grace, she was satisfied to proceed on the basis that sexual abuse was accepted to have occurred, which was not an unreasonable approach for her to have taken.

11.90 During her evidence to the Commission, Dr. Moran, quite correctly, did not purport to contend that what her report had to say about Grace on the matter of sexual abuse constituted evidence that Grace had, in fact, been subjected to such abuse. Rather, she explained that what her report said on that matter had been based upon information that was provided to her by Ms B.

11.91 The Commission is, therefore, not satisfied that the question of whether or not Grace was subjected to sexual abuse can be answered by reference to Dr. Moran's report.

12. Psychosexual assessment

Dr. Caffrey

Preliminary

12.1 In January, 2010, Dr. Caffrey, Consultant Psychologist, was engaged by the HSE to carry out a psychosexual assessment on Grace. He was not Grace's psychologist and was not involved with her treatment.

12.2 Dr. Caffrey specialised within the area of sexuality and sexual abuse. He worked part time within St. Michael's House, a disability service, and worked with disability services throughout the country as a private consultant. Dr. Caffrey was a lecturer in the School of Psychology in Trinity College, Dublin and taught courses on human sexuality and personality theory and was involved in the training of psychologists. He also trained instructors to teach sex education courses at levels of intellectual disability.

12.3 Dr. Caffrey said that the majority of his work involved investigating sexual abuse within organisations, or engaging with particular individuals who were either sexual abusers or sexually abused. Dr. Caffrey said that he did a lot of risk assessment regarding the dangers of some individuals to persons with intellectual disabilities.

Psychosexual assessment – remit

- 12.4 Dr. Caffrey was engaged by Ms Browne in January, 2010 to conduct a psychosexual assessment with respect to Grace.
- 12.5 Dr. Caffrey explained that, in the context of an assessment, he might have a number of different objectives, not just that of establishing whether or not sexual abuse had occurred. He said that protection or therapeutic intervention might be necessary and, in the circumstances of what he was assessing, outlined further objectives, such as a person's educational needs or whether others also needed protecting.
- 12.6 Dr. Caffrey observed that it might not be possible, when dealing with a person with Grace's profound disabilities, to obtain information that would "*stand up legally*". In such cases, one had to decide which of the objectives to pursue within an assessment. Speaking of assessments generally, he said that if one was "*fortunate enough*", one might have enough evidence to bring the case in question "*down the legal route*."
- 12.7 Grace had been moved from Mrs. X's by the time Dr. Caffrey became involved in her case. That being the case, the goal of protecting her from further abuse, if abuse was occurring, had been addressed to the extent that she was in a residential placement. However, he said that the complication inherent in that was that of moving her from a world in which she was very, very imbedded to a new world, with all of the difficulties that occur as a result.
- 12.8 Dr. Caffrey said that his primary goals were, first, examining whether it was possible to establish whether sexual abuse had occurred and, secondly, looking at issues regarding safety and protection.

Access and available information

- 12.9 Aspects of the underlying information provided to Dr. Caffrey for his assessment were the subject of investigation by the Commission under its Terms of Reference. The facts established by the Commission following consideration of the evidence examined on these aspects, are reported in other chapters of the Commission's reports.

- 12.10 Owing to Grace's mental health in January, 2010, Dr. Caffrey was advised that he would not be able to conduct a direct assessment of her. Her mental health had deteriorated and she had suffered a psychotic episode around this time. Instead, he was to conduct a file review of her case. Dr. Caffrey did not meet Grace; he did, however, observe her in Day Service Provider A for approximately 20 minutes. He said that this was "... *just to get to know what the person looked like basically and watch the communication patterns and stuff.*" Dr. Caffrey also attended Waterford on five occasions between February and November, 2010 for various purposes in conjunction with his assessment. He spoke to Ms B on a number of occasions and to Mr. Smith on two or three occasions.
- 12.11 Dr. Caffrey accessed background information in Grace's case, which included information on the previous third-party allegations of sexual impropriety relating to the Family X placement, all information about her absences from her day placement, issues of bruising, marks and scratches to her, and information about both of her attendances at Waterford Regional Hospital. Up to the time of his assessment, Dr. Caffrey also had access to file notes on Grace and reports and correspondence about her case, including internal HSE emails and the minutes of Vulnerable Adult Committee ("VAC") meetings. The more recent file notes and correspondence set out the concerns that he was to investigate regarding whether Grace had been sexually abused. He told the Commission that his impression at the time was that Mr. Smith was "*fairly convinced*" that she had been. Dr. Caffrey said that "[f]rom conversations my impression was that he was fairly, that he was convinced that abuse was taking place in a number of areas in terms of neglect, financial abuse, perhaps, and physical abuse, so there was a lot of things happening, and that included sexual abuse." Dr. Caffrey said that he gleaned "*something very, very similar*" from his conversations with Ms B.
- 12.12 The persons with whom Dr. Caffrey spoke for the purpose of his assessment included Dr. Ferrari, Dr. Syed, Ms B, Ms D, Mr. Smith, and Ms Browne. He did not meet with Ms R or Mr. M and said that he felt that he had enough information at that stage from the two managers involved in Grace's case. Dr. Caffrey said that "[w]hat I was looking at, I was looking at information at that point in time, not necessarily historical stuff."
- 12.13 Dr. Caffrey said that he looked at Family X's background to consider whether it was dysfunctional or not or if there had been criminality. In this regard, he looked at the

matters raised in Mr. Smith's report of March, 2008 and referred to the reference to "*potential misappropriation of funds*" by Mr. X in the past. Dr. Caffrey did not have evidence of a conviction of Mr. X, but said that he considered this as "*soft information*".

12.14 Dr. Caffrey did not contact Mrs. X in the course of his assessment.

Assessment

12.15 In conducting his assessment, Dr. Caffrey listed all the men whom he thought might have had access to Grace. He said that "[w]hat I was attempting to do there was just to figure out who might be, if there was a male perpetrator, who might have access to [Grace] at this stage". He approached this particularly within Grace's "*family world*" and listed Mrs. X's husband, her brother, her nephew, her grandson, and Beta. This was not an exhaustive list. Dr. Caffrey said that the list of persons whom he could find from a male perspective was ongoing and explained that the names either came up in documentation or were provided by Mr. Smith. Dr. Caffrey said that he would also have looked at and talked about Mrs. X as a possible perpetrator.

12.16 Dr. Caffrey said that some sexually specific behaviours were reported after Grace moved into the residential placement, at a time when, according to Dr. Ferrari, Grace was extremely distressed and had suffered a psychotic episode. Dr. Caffrey said that he, therefore, considered Grace's mental health and what he described as the "*sexually specific symptoms*" together.

12.17 Dr. Caffrey said that, in terms of his assessment, bruising to Grace's breast and thigh (in connection with the hospital attendance in March, 2009) "*jumped out*" at him. He said that, in a case of sexual abuse, very often a person could be held down leading to bruising in both of those areas. He said that it was not that uncommon.

12.18 With regard to Grace's visit to Waterford Regional Hospital in August, 2008 for bruising around the eye, Dr. Caffrey said that the focus there was on possible neglect or physical abuse, not sexual abuse. He observed that "*if neglect or physical abuse is taking place and there are other things operating around, there is also the possibility that sexual abuse is taking place*". He, therefore, also looked at what appeared to be the general care or lack of care of Grace at that point.

Indices of concern

- 12.19 In the notes he made during the course of his assessment, Dr. Caffrey set out his “indices of concern” arising from his examination of Grace’s case as follows: *“HSE to move her, previous allegation(s), bruising to breast & thighs, sleeping arrangement unwillingness to give up [Grace], particularly [Mr. X].”* He also noted that Grace’s vulnerability was a concern and his understanding was that Mrs. X had said at some stage that Grace *“would do anything any one [would] tell [her] and go off with anyone who leads her.”*
- 12.20 In terms of the unwillingness of Family X to give up Grace, Dr. Caffrey clarified that this could, in his view, also be motivated by financial issues. He explained that it could also be *“having a victim that’s available to you and people can often not want to let people move into residential care.”* It was in that regard that he said that it was a question mark for him.
- 12.21 In his evidence, Dr. Caffrey referred to Grace’s vulnerability and described her as a *“perfect victim in many ways”*. She had communication difficulties and what were described as several sexualised behaviours, including stripping. In addition, he referred to *“the family secrecy”* and the *“withdrawal from services”*, referring to Grace’s absences from her day placement.
- 12.22 He said that *“... when you have got a sort of a dynamic and, sort of, a system operating like that with a number of different things, with the secrecy, with you know some sexual, possible sexualised behaviours, the panties, sleeping arrangements, a number of people having access to [Grace], her lack of capacity to defend herself or know what was appropriate or what wasn’t appropriate, when you start putting together you are then looking, you are beginning to look at a highly vulnerable person.”*
- 12.23 With regard to the above, Dr. Caffrey also made a note that Grace had *“thongs for panties”*. In his evidence, Dr. Caffrey recalled that *“I think it was Mr. Smith, when they were gathering things for her to go to residential placement, I think they were looking for her panties and what they had was thongs, which [is] highly sexual sort of underwear I’m told.”* It was clear from the evidence, however, that the only reference to underwear arose in connection with a record which had been made of the contents of a box of clothing for Grace, some of which appeared to be newly purchased, which

was delivered to Day Service Provider A on behalf of Mrs. X on 19th August, 2009, reported upon above at paragraph 11.16.

- 12.24 There was no evidence to the Commission that Grace wore thongs as underwear. All of the evidence with respect to Grace's underwear supports a finding that she wore what might be termed as ordinary underwear, often sent in from home because of incontinence concerns and regularly changed in Day Service Provider A. The Commission is not satisfied that Dr. Caffrey's concerns on this matter, in particular his understanding that she was wearing thongs (which he had described as highly sexual sort of underwear), were substantiated by the background information.

Behaviours

- 12.25 During his evidence, Dr. Caffrey recalled a conversation with Ms B in July, 2010. This was followed by her letter of 29th July, 2010 referred to above at paragraph 11.55, setting out some of Grace's behaviours. During that time, there had been a lot of what appeared to be sexualised behaviour by Grace (about which Dr. Caffrey had not spoken to Dr. Ferrari). That behaviour happened when Grace was quite ill. At a later point, which Dr. Caffrey thought was November, 2010, he said that he had spoken to staff, and that those behaviours had ceased.
- 12.26 During a meeting with Ms B on 3rd November, 2010, Dr. Caffrey recorded in his handwritten notes that "[Grace] *went through [a] period of rubbing against people with [her] genitals. Wishing to kiss people on [the] lips, [and was] self stimulating*". In this regard Dr. Caffrey commented during his evidence that Grace was "*touching herself when she was having a – she was rubbing her genitals when she was having a shower*". He also went on to record in his notes that she "[h]ad a poor time mental health wise, deteriorated a lot. Has settled and the inappropriate sexual [behaviours] have decreased.." He also noted that she "*now masturbates in bath and left to privacy*." Dr. Caffrey explained in evidence that the word "masturbate" might not be an accurate word and that the term "self-stimulate" might be better, saying that people could touch their genitals for many reasons, such as for comfort, to reduce anxiety, and for pleasure. In this regard, he noted that Grace "*..had been self-stimulating but she is left to the privacy of her own, left private at that point at time, which is a fairly standard process in disability services*".

12.27 In November, 2010, Dr. Caffrey also recorded that there was *"no sexualised behaviour to self or other people noted"*. He said that this was in contrast to February or March, 2010, when a lot of behaviours had been reported as sexualised. In this regard, Dr. Caffrey pointed out that Grace was *"very very disturbed"* at that time and had had a psychotic episode. He pointed out that *"the two medical people [Dr. Syed and Dr. Ferrari] had said to hold on and see how her medication works and to see if her mental health improves. It would seem as though her mental health had improved and a lot of the sexualised behaviour that could be considered sexualised behaviour before seemed to dissipate"*. Dr. Caffrey observed that *"it may have been more due to her psychotic condition than the fact that she had been [sexually abused] - you can look at that, those hypotheses"*.

12.28 Dr. Caffrey said that initially they thought that Grace had been primed to part her legs for the purpose of sexual intercourse but that staff looking after her said that it tended to happen when her incontinence pads were being changed.

12.29 His notes of what was relayed to him about Grace's behaviours during his assessment recorded that:

"No sexually specific behaviours noted by [Ms D] + [CW10]. No sexual self-stimulatory behaviours noted. No touch (inappropriate sexual) of others clients or staff."

"All incidents of disrobing were connected with incontinence, (urinary)...Incident on bus reported to be related to incontinence also".

"Touch not sexual in nature".

12.30 Dr. Caffrey told the Commission that the picture that was presented of Grace was of a non-sexual person. He said that his conclusion was that Grace's touching of staff was non-sexual in nature, recalling that a staff member had said that the touch that Grace engaged with was not of a sexual nature. Dr. Caffrey observed that that would be consistent with Grace's overall level of development. Speaking of persons with intellectual disabilities, Dr. Caffrey's evidence was that *"[r]ather than looking for gratification in relation to another person, gratification is very often or usually around [the person] themselves and their own focus."* Dr. Caffrey said that he therefore noted *"no sexual symptoms. Asexual"*.

12.31 Dr. Caffrey also noted that Grace had no major history of psychological symptoms of massive distress, although he noted that this was not definitive as to whether abuse had occurred.

Mark on Grace's spine

12.32 Dr. Caffrey also made a note from the day centre records of a *"mark at top of [Grace's] bottom??"* The note went no further than that. In his evidence, he said that *"it had been reported quite a number of times since she was living at home that she had a possible carpet burn at the top of her bottom and I was wondering had that ceased since she came into care."*

12.33 During his evidence, Dr. Caffrey clarified that no one had actually described the mark as a *"carpet burn"* to him. He said that he was looking at whether it was potentially so, but he noted during this evidence that it could have been due to lots of other things as well. He said that it was *"something to keep in mind"*. Dr. Caffrey referred to this in his report as *"skin friction marks"* and speculated as to whether they could occur in sexual intercourse.

12.34 The origin of Dr. Caffrey's note about this mark was in Mr. Smith's note on Grace's file of his conversation with Ms D dated 25th June, 2008 which stated: *"Last week [Grace] appeared to have sores on her spine. These were red marks and not bruises. I asked if these marks were more like friction burns and [Ms D] said that they were. She did not know the reason and she had not discussed this with Mrs. [X]"*. He noted that she did not think that it was worth involving a doctor as the red marks had disappeared and the scratches were of *"indeterminate origin"*. This exchange between Mr. Smith and Ms D at this time is reported on in Chapter 5 of Part 1 of Volume 1.

12.35 There were notes of skin abrasion marks on Grace's back, associated with Grace's incontinence wear, as reported in Chapter 2 of this Volume.

12.36 With regard to the reference in Mr. Smith's note to apparent sores on Grace's spine the previous week, CW6 (countersigned by Ms D) had made a note of marks to Grace's spine on 18th June, 2008, which recorded that *"when toileting [Grace] this morning I noticed four separate red marks on [her] spine"*. The next day Ms D made

a further entry recording that “[Grace] was observed to have four ? pressure marks on her spine, Body chart completed.”

- 12.37 Ms D said that Grace very often presented with marks that were not overly concerning marks. They documented them in the day centre and reviewed them if there was concern or considerable concern. Ms D thought that, on that particular day, the four marks on the base of Grace’s spine might possibly have been caused by the incontinence wear that she wore at nighttime. She said that Grace had rashes, which Mrs. X attributed to the wearing of incontinence wear.
- 12.38 Ms D did not recall speaking to Mrs. X about these particular marks. She said that she had no reason to doubt what Mrs. X had said about the marks and, as far as Ms D was concerned, they were not concerning marks. She said that, if she had had a concern that they were the result of a non-accidental injury, they would have reported it straight away to Mr. Smith.
- 12.39 In terms of Mr. Smith’s note above, Ms D did not recollect this conversation with Mr. Smith and could not recollect saying that the marks were friction burns or that she thought they were friction burns. She told the Commission, however, that that did not mean that she did not say that. However, when asked if she viewed the marks as friction marks at the time, she said: *“I can say with some certainty that I didn’t. What I had documented was that they were pressure marks. I didn’t describe them myself as being friction marks.”*
- 12.40 The Commission is satisfied that Ms D did not view the marks to Grace’s lower spine as *“friction marks”*. Rather, she considered that they were *“pressure marks.”* The Commission is satisfied on the evidence that Ms D’s record of them does not support a conclusion that they were due to sexual abuse of Grace.

Sleeping arrangements

- 12.41 Dr. Caffrey also recorded in his notes that he was told that Grace shared a bed with Mrs. X. In his evidence, he related this to the information that he had obtained about Mrs. X’s and Z.Z.’s sleeping in the same bed, and he said that he thought that this also applied to Grace, noting that, in fact, they slept in the same room. Dr. Caffrey observed in this regard that “[t]he lack of boundaries, very often around sexual abuse

there is usually some problems around boundaries". He described these as issues that were coming to mind as he made his notes during the assessment.

Previous allegations

12.42 The fact of other allegations of sexual misconduct having been made by third parties, as referred to earlier, was a significant concern for Dr. Caffrey in preparing his psychosexual assessment in Grace's case. In this regard, he observed during his evidence that *"sometimes when you're looking at a whole area of sexual abuse you don't just have one victim, you may have a number of others"*.

Dr. Caffrey's report

12.43 Dr. Caffrey's report was completed on 4th November, 2010.

12.44 According to Dr. Caffrey's report, the focus of his intervention was *"[t]o investigate a concern among HSE personnel that [Grace] may have been sexually abused at some point in the past. There were some sexualised behaviours that caused concern noted in the file and others that arose since [Grace] entered residential placement. It was also an aim to offer suggestions re [Grace's] care planning."*

12.45 In addressing the signs and symptoms that caused concern regarding sexual abuse, Dr. Caffrey identified two possible physical symptoms as:

"(a) Fingertip bruising of breasts and thighs...

(b) Marks at the base of [Grace's] spine."

12.46 It should be noted that the bruising to Grace's breasts and thighs had not been described as being suggestive of *"fingertip"* by Dr. O'Gorman. That was a description that came from Day Service Provider A personnel which was subsequently adopted by Mr. Smith.

12.47 In terms of *"[s]exual [i]ssues"*, Dr. Caffrey identified:

"(a) [Grace's] attempting to pull the social worker onto a trolley in the A&E [in Waterford Regional Hospital];

(b) *Possible touching of person's breasts in the A&E.*

(c) *Disrobing in unit and on bus.*

(d) *Since entering residential accommodation other behaviours have been noted. When continence pads were being changed [Grace] lay on bed and opened her legs which could have been interpreted as a sexual position.*

(e) *Pelvic gyrations while being showered.*

(f) *[Grace] was referred to sexual assault unit in Waterford for investigation."*

12.48 Ms B said in her evidence that she had not considered Grace's behaviour of pulling her onto a trolley at the Emergency Department in Waterford Regional Hospital as being sexual in nature.

12.49 When considering the behavioural concerns, Dr. Caffrey's report stated that *"in considering the disrobing – staff noted that each incident of disrobing occurred within the context of a continence / incontinence issue and would not appear to have a sexual content."*

12.50 Dr. Caffrey also reported that *"[t]he sitting or lying on the bed and opening of legs – again was within a self care context and it could have been [Grace's] facilitating the care staff [to] place pads on her which may have been a feature in the past in her life."*

12.51 He reported that *"[t]here were no witnesses to any sexual events taking place"*.

12.52 Dr. Caffrey reported that *"[t]he incident at the A&E re touching a person's breasts was considered. There was conflicting views in relation to the intent of that possible contact."* In evidence, Dr. Caffrey said that there was a divergence of opinion between Mr. Smith and Ms B as to whether it was sexual or not.

- 12.53 He also reported that “[Grace] *regularly pushes up against and pushes people and the person who was at the receiving end of the touch was very definitely of the opinion that it was not sexual in nature.*”
- 12.54 In his evidence, Dr. Caffrey said that he learned this information at the time from either CW10 or Ms D.
- 12.55 Dr. Caffrey also noted that “[t]he SATU report was not available despite repeated efforts to gain access to the content. However, at that time conversations took place between the Health Board Team Leader and the SATU personnel. The social worker with another social [worker] returned [Grace] to [Mrs. X’s] care, so one assumes that no significant information re sexual abuse was available at that time”.
- 12.56 Dr. Caffrey’s report stated that “[t]he gyrations in the shower have ceased when this author spoke with the staff.” It went on to state: “However, the fingertip bruising of breasts and thighs remains unexplained” and that “[Grace’s] repeated attempt to pull the social worker onto the trolley in the A&E remains unexplained.” It also stated: “Skin friction marks noted at the base of her spine remain unexplained”.
- 12.57 Dr. Caffrey’s report stated “[i]n discussion with staff who would have known [Grace] for a number of years there were no sexually specific behaviours noted.” Dr. Caffrey explained that this referred to the later phase when he saw her, when her mental health improved. In this regard, he reported that “[t]here was no sexual self stimulatory behaviours or inappropriate touch or contact with others either clients or staff noted at that time.”
- 12.58 Dr. Caffrey concluded that “[i]n June 2010 there was no clear evidence to suggest that sexual abuse had taken place. There were unexplained symptoms but there could have been a number of possibilities as to how they arose”. In evidence, Dr. Caffrey corrected that aspect of his note and said that it would have been more accurate to say November, 2010, when he had prepared his report.
- 12.59 Under the heading “[s]ubsequent [d]evelopments”, Dr. Caffrey had recorded certain behaviours reported to him as follows:

“[Grace] began to exhibit what appeared to be inappropriate sexual behaviours.

- *She attempted to kiss staff on lips.*
- *She self stimulated by rubbing her genitals against staff members.*
- *She also self stimulate[d] by rubbing against objects e.g. a chair.*
- *Although unclear, she appeared to touch staff sexually.*
- *She was sexually stimulating herself while bathing”.*

12.60 In his evidence, Dr. Caffrey explained that he was referring to Grace’s behaviour as they moved into May/June and July, 2010, where she was quite disturbed and had been involved in many things like biting. Dr. Caffrey explained that she did not have those signs/symptoms and then, when she deteriorated mentally, a number of them emerged. With the deterioration in her mental health, these behaviours came to the fore. The evidence indicated that Grace was suffering psychosis around this period.

12.61 Dr. Caffrey observed in his report that:

“[c]oncurrently with this [Grace’s] mental wellbeing deteriorated significant[ly], which may in part or fully explain her behaviours.

She is being treated by Dr. Nan Ferrari, Consultant Psychiatrist and Dr. Akhtar Ali Syed, Principal Psychologist at present.

At the time of writing this document her condition is reported to be improving with only the self stimulating while bathing occurring. (This incidentally is quite a normal sexual activity, when done in privacy, for people with an intellectual disability)”.

Report’s conclusions

12.62 Dr. Caffrey’s report concluded as follows:

“There is insufficient evidence to support the hypothesis that [Grace] has been sexually abused.

However, there are significant risk factors in [Grace's] previous environment to cause serious concerns."

12.63 Dr. Caffrey reported that these risk factors fell into three categories and elevated the level of risk of Grace. The factors were threefold:

- "1 [Grace's] vulnerability due to her disability.*
- 2. Systemic factors in the care environment.*
- 3. Specific relevant factors in the [Family X] household."*

Dr. Caffrey's evidence on his conclusions

12.64 Commenting on the basis upon which he formed his conclusions, Dr. Caffrey noted that there was no clear evidence that sexual abuse had taken place. He said that:

"There was no physical evidence, although that very often is not present and it can be very, very difficult to avail of. There were no witnesses. There didn't appear to be significant symptoms prior to. There was no evidence to suggest that abuse had taken place, to support the hypothesis. There wasn't sufficient evidence."

12.65 Dr. Caffrey told the Commission that the fact that there was not sufficient evidence, did not mean that there would not have been a lot of *"concerns, worries, wondering about what was happening"*. He said that Grace looked incredibly vulnerable and in a difficult situation.

12.66 Dr. Caffrey made observations during his evidence on the difference between having suspicions and having proof. He commented that, in many cases, one would have very strong suspicions that abuse was taking place, saying:

"... but you couldn't get enough to actually prove it and if taken to a court of law or other places your arguments would have been – so to prove it on, say, a legal basis is extremely difficult".

- 12.67 He said that, on a clinical basis, one might think that the cumulative effect of the factors in Grace's case would make one suspect, but he observed that "*.. there is a difference between having enough evidence to suspect and prove abuse. Very often if you cannot get enough evidence to prove, you start looking at what are the other goals.*" That goal, as set out in his report, was to offer suggestions about Grace's care planning.
- 12.68 Referring to the factors he had assessed in Grace's case, Dr. Caffrey observed that, from a legal perspective, "*it certainly wouldn't have been strong enough to prove in any way sexual abuse*". He said "*very often if you cannot get the legal perspective, or if you can that is wonderful because you will have enough information with that.*" In a civil setting, Dr. Caffrey said that you would "*probably not*" reach the balance of probabilities but you "*would have a better chance.*"
- 12.69 It is appropriate to observe at this juncture that the manner in which Dr. Caffrey expressed some doubt between suspicion and proof, was illustrative of the challenge that lay at the heart of the work of the Commission, namely that of separating matters that could be factually established on the basis of evidence, from suspicions and supposition.
- 12.70 Having appropriately emphasised the fundamental difference between having suspicions, on the one hand, and the existence of proof, on the other, there was further discussion in the course of Dr. Caffrey's evidence as to what weight he put on suspicions in the absence of sufficient evidence.
- 12.71 Notwithstanding the conclusion of his report that there was insufficient evidence on the question of whether Grace had been sexually abused, Dr. Caffrey said that his view was that she was extremely vulnerable and that she was "*probably sexually abused*". Initially expressing the view that there was not evidence to meet a civil standard of proof (the balance of probabilities), Dr. Caffrey went on to give a view that this "*certainly*" tipped fifty *per cent*, before reverting to state that "*again there wasn't evidence, there wasn't hard evidence to justify that.*"
- 12.72 Dr. Caffrey said that, looking at some of the symptoms and some of the things that were wrong, "*the context, the family environment, allegations, the thongs, et cetera, et cetera, all of that began to accumulate and come together and I formed the opinion that there was a significant probability that abuse had occurred but [it was] very, very*

difficult to prove.” However, he again qualified this by stating that “in my view there was not sufficient hard evidence to support the hypothesis that [Grace] was sexually abused.”

12.73 With respect to this evidence, Dr. Caffrey said: *“I gave you a personal opinion on that in terms of thinking whether she was or wasn’t abused, a professional personal opinion on it. If you take it and move it into a body other than my own personal professional opinion there is not sufficient evidence to prove that.”*

12.74 Dr. Caffrey confirmed that the conclusion in his report was that there was insufficient evidence to support a hypothesis that Grace had been subjected to sexual abuse, and that there was insufficient evidence to support a prosecution, and that this was his view. He said, however, that when looking at it from a clinical point of view *“you look at the vulnerability, you look at the fact that others would appear to have been abused, others that we know of would appear to have been abused will increase the likelihood that she may well have been abused. I think she may well have been abused.”*

12.75 In further discourse on the issue, Dr. Caffrey said that *“there was not sufficient evidence to prove that she was abused. There was sufficient evidence to be concerned, worried and to take an alternative track rather than attempting to go down the criminal route, and that was to look after other aspects and other parts of her world.”* Dr. Caffrey said that he could not find sufficient evidence to establish a criminal prosecution and then added *“also probably a civil one as well”*. He qualified the view he had expressed at the Commission regarding the likelihood that sexual abuse *“could have occurred”*, by noting that *“you can suspect, but not prove.”*

12.76 Ultimately, addressing aspects of his testimony at the conclusion of his evidence, in particular on the question of suspicion, as distinct from evidence, Dr. Caffrey drew a distinction between the legal area and his clinical approach, and between suspicions and proof, in the following way. He confirmed that it was his view that, from a legal perspective, a hypothesis that Grace had been sexually abused could not be proved *“beyond a reasonable doubt”*. He also confirmed that he did not, in fact, think that sexual abuse could be proved on the legal test of the balance of probabilities in civil matters (as to what is more likely to have happened than not). Dr. Caffrey confirmed that the essence of his evidence to the Commission on the question of sexual abuse was that, from a clinical perspective, *“it is my suspicion.”*

Findings

- 12.77 The conclusion in Dr. Caffrey's report that there was insufficient evidence to support the hypothesis that Grace had been sexually abused remained his view at the Commission and was effectively not altered by his evidence. Notwithstanding Dr. Caffrey's evidence as to his suspicion from a clinical perspective and his identification of risk factors, as reported above, there was insufficient evidence to support the hypothesis that Grace had been sexually abused when reporting the outcome of his assessment to the HSE.
- 12.78 The Commission is satisfied that, having regard to the purpose of his assessment, there was no reason to doubt that, had Dr. Caffrey concluded on foot of it that Grace had probably been subjected to sexual abuse, he would have reported this conclusion to the HSE.

13. Phase Two considerations

- 13.1 The existence of allegations with respect to other service users in the same placement as Grace is, of itself, a matter of significant concern. However, for the purpose of its Phase One investigations into Grace's care, the Commission is satisfied that it has taken evidence from relevant persons who came into contact with Grace and elicited their observations with respect to her within the home of Family X or otherwise. The Commission is satisfied that its investigations in Phase One with respect to Grace have been sufficiently comprehensive as to capture available evidence, including medical evidence pertaining both to her care and, bearing in mind the particular subject matter of this Chapter, whether there was evidence that established that she had been sexually abused.
- 13.2 The Commission is satisfied that, having conducted its investigations in Phase One in the manner that it has done, it has been able to investigate any concerns about sexual abuse of Grace, without straying upon or pre-determining the issues of any other person which might later be investigated.

14. Findings on the question of sexual abuse

- 14.1 This Chapter has examined the evidence with respect to Grace's behaviours before and after her move into a residential placement in July, 2009 and the concerns which

arose that those behaviours indicated that she had been subjected to previous sexual abuse.

- 14.2 In the light of all of the evidence with respect to Grace, including the medical evidence considered in detail above and in this Volume, the Commission cannot be satisfied that those behaviours giving rise to concerns that she had been sexually abused, particularly those which developed following her move to a residential placement in July, 2009, properly indicated or established that she had been subjected to prior sexual abuse.
- 14.3 Insofar as Grace's post-move behaviours are concerned, it is important to report that the Commission is satisfied that, in the aftermath of the move, she suffered what was, in effect, a collapse of her mental health. The Commission considers that, in all likelihood, this was substantially attributable to the profound impact of the move upon her and the upheaval in her life brought about by the change in her living arrangements and the separation from her carer of the previous 20 years. The stark reality is that Grace's life changed suddenly and fundamentally overnight, contributing to the development of the behaviours reported upon above.
- 14.4 The evidence considered by the Commission in this Chapter did not establish that Grace had been subjected to sexual abuse over the years that she lived with Family X and the Commission is accordingly satisfied that for it to make such a finding would be unsafe and unsupported by the evidence considered in Phase One of its investigations into her care.

END

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CHAPTER 5

1. Introduction

- 1.1 Pursuant to Terms of Reference V. a) and VIII. a) and to the definition of “*abuse*”¹ contained in the Terms of Reference, the purpose of this Chapter is to consider and report upon the evidence provided to the Commission on whether Grace was the subject of abuse of a financial nature while in the care of Family X. This was a pivotal issue to be investigated under the Terms of Reference set for the Commission.

Terms of Reference

- 1.2 The term “*abuse*” is defined in the Terms of Reference to mean:

“any act, or failure to act, which results in a breach of a vulnerable person’s human rights, civil liberties, physical and mental integrity, dignity or general well-being, whether intended or through negligence, including sexual relationships or financial transactions to which the person does not or cannot validly consent, or which are deliberately exploitative. Abuse may take a variety of forms” (emphasis added).

- 1.3 The Terms of Reference define “*vulnerable adult*” as:

“an adult who may be restricted in capacity to guard himself / herself against harm or exploitation or to report such harm or exploitation. Restriction of capacity may arise as a result of physical or intellectual impairment. Vulnerability to abuse is influenced by both context and individual circumstances.”

2. Chapter overview

- 2.1 On consideration of the evidence, the Commission is satisfied that the following are the aspects to be considered and reported upon in establishing the facts as to whether Grace was the subject of financial abuse over the period that she was in receipt of social welfare payments while in the care of Family X:

¹ The term “*abuse*” is defined in the Terms of Reference at Part XI.

- Grace's Disabled Person's Maintenance Allowance/Disability Allowance;
- Mrs. X as a Type 2 Agent;
- the manner in which Grace's DPMA/Disability Allowance was spent up to July, 2009;
- discussions between Mrs. X and Ms B following Grace's move;
- the application of Grace's Disability Allowance - post July, 2009; and
- findings on the question of financial abuse.

3. Grace's Disabled Persons Maintenance Allowance / Disability Allowance

- 3.1 As a person with profound intellectual disability and for the reasons outlined in other chapters within this Volume, Grace was evidently unable to take care of her financial affairs. Given her disability, she was eligible for Disabled Persons Maintenance Allowance ("DPMA"), which was administered by the SEHB, and she received her first payment of that allowance on 23rd September, 1996.
- 3.2 DPMA was replaced by the Disability Allowance Scheme in 1996 and Grace received Disability Allowance from 2nd October, 1996. The Disability Allowance Scheme was administered by the Department of Social Welfare (as it was known then).²
- 3.3 With regard to the time period that she was placed with Family X, therefore, Grace was paid either DPMA or Disability Allowance from 23rd September, 1996 up until 22nd July, 2009.³ It is this money, which Grace was entitled to in her own right, that is the subject of the Commission's inquiry under the aforementioned Terms of Reference.

Payments in favour of Mrs. X

² The Department of Social Welfare was subsequently renamed as the Department of Social Protection. The Disability Allowance Scheme remains under the administration of the Department of Social Protection.

³ Grace was moved from the home of Family X into a residential placement on 17th July, 2009. The move is reported upon in Chapter 20 of Volume I, Part 2.

- 3.4 It should be stated at the outset that, in her role of caring for Grace, Mrs. X was entitled to social welfare benefits in her own right. These included, among others, Foster Carer's Allowance initially and, subsequently, Carer's Allowance. There was no legal obligation or requirement on Mrs. X's part to use this money on Grace or for Grace's benefit. This was money that Mrs. X received for caring for Grace, to be used for her own purposes. Any suggestion that there was an obligation or requirement upon Mrs. X to use this money for Grace's benefit is misconceived and incorrect.
- 3.5 The focus of the Commission's investigation with respect to any potential financial abuse of Grace, therefore, relates solely to the DPMA / Disability Allowance which was Grace's money and was to be used solely for Grace's benefit.

Entitlement to Disability Allowance

- 3.6 Ms Michelle Conroy, an Assistant Principal Officer in the Disability Allowance Section of the Department of Social Protection (the "Department"), gave evidence to the Commission regarding the payment of DPMA and Disability Allowance to Grace.
- 3.7 Ms Conroy outlined during her evidence how Grace, by virtue of her disability, was eligible for DPMA on attaining the age of 16, in November, 1994. Prior to the introduction of Disability Allowance, each health board administered a DPMA Scheme, with payments being made directly to service users.
- 3.8 On the establishment of the Department's Disability Allowance Scheme in 1996, the Department took over the function of making payments to the health board service users and integrated the administration of the health board allowance (DPMA) with its new scheme. Persons who were then in receipt of DPMA were transferred to the Department's scheme for Disability Allowance.
- 3.9 In giving evidence to the Commission, Ms Conroy said that under the new means-tested Disability Allowance Scheme, an eligible person who had an illness or a medical condition that was expected to last for at least a year and who was substantially restricted in obtaining employment could receive Disability Allowance.
- 3.10 Ms Conroy said that the claimant had to be resident in the State and to be of working age, *i.e.* between the ages of 16 and 66. Ms Conroy gave evidence regarding the

criteria for eligibility for the Disability Allowance for persons suffering from *“injury, disease or physical or mental disability”* and said that there had been *“a lot of changes to the means assessment but no changes really to the medical qualifying criteria”*.

Commencement of payments to Grace

Domiciliary Care Allowance

- 3.11 Domiciliary Care Allowance is a payment in respect of a child with a severe disability. Mrs. X claimed Domiciliary Care Allowance for caring for Grace up until 1st September, 1996.
- 3.12 Once the payment of Domiciliary Care Allowance relating to the care of Grace ceased in September, 1996, Grace was paid DPMA and later, Disability Allowance.

Disabled Persons Maintenance Allowance

- 3.13 As outlined above, although Grace reached the age of 16 on 24th November, 1994, the age from which an entitlement to DPMA generally arose, she did not start to receive DPMA until 23rd September, 1996 and was then in receipt of Disability Allowance from 2nd October, 1996.
- 3.14 The position was that Mrs. X continued to receive Domiciliary Care Allowance beyond Grace’s 16th birthday, until two months before her 18th birthday. It is clear, however, that on 1st February, 1995, it was recommended by a Community Welfare Officer that Grace would receive DPMA in the sum of £61.00.
- 3.15 Mr. Dermot Halpin,⁴ who was an administrator in the SEHB in 1996, explained to the Commission that Domiciliary Care Allowance, in general, finished when the child attained the age of 16 because the DPMA (as it was at the time) was paid from the age of 16. This was, he said, provided the person met the medical criteria and the means test criteria. There was no means test for Domiciliary Care Allowance. It was, Mr. Halpin said, purely an administration issue.

⁴ In 1996, Mr. Halpin was the Administrator in Waterford Community Care. He was a Grade 7 officer of the health board and the senior administrative person within Waterford Community Care

- 3.16 During his evidence to the Commission, Mr. Halpin said that a child could be entitled to the Domiciliary Care Allowance, but not necessarily to DPMA. That was why, as in Grace's case, the payment of Domiciliary Care Allowance might continue to 18 years of age, when a person would have eligibility for other social welfare payments.

Payment in Grace's "own right"

- 3.17 In a letter from Mr. Halpin to Mr. X dated 15 January, 1997, almost two months after Grace had turned 18 years of age, Mr. Halpin stated as follows:

"Further to your letter regarding the discontinuance of the Foster Care Allowance and Domiciliary Care Allowance in respect of [Grace]. As discussed with you subsequently on the telephone I can indicate that following the granting of Disability Allowance (formerly known as Disabled Persons Maintenance Allowance) the status of Foster Care Payment and Domiciliary Care Allowance changed considerably. In respect of the latter the Domiciliary Care Allowance cannot be paid at the same time as the Disability Allowance in that it ceases payment on reaching age 16 or at latest aged 18 years if the Disability Allowance has not been granted. The Foster Care Allowance is a payment made in respect of the Foster Parents to enable them to provide for the Foster Child, however, once the Foster Child has been granted a payment in her own right payment of Foster [Care] Allowance must cease...

I must confirm that the foster payment will not be restored as [Grace] is now a recipient of Disability Allowance, however, I suggest that you and your wife pursue the matter of overall entitlement for your own income either through the Department of Social Welfare or at the local Community Welfare Officer as it would seem to me that you may have an entitlement to an increase in your current level of payment" (emphasis added).

- 3.17 In an undated letter to the Department, which is thought to have been received by it on 3rd November, 1997 (at the same time as an application for Carer's Allowance by Mrs. X arising from her care of Grace), and in acknowledging that the DPMA was a payment made in Grace's favour, Mrs. X stated as follows:

“I have [Grace] 9 years and was paid Foster [Carer’s] Allowance for her till the 22nd October, 1996 when she became 18 years of age. She also has her own money in her own rights D.P.M.A. That leaves me without Foster Care Allowance. I’m still doing the same work as I have done for the 9 years without money” (emphasis added).

Amount of Disability Allowance received while in the care of Family X

3.19 From documentation provided to the Commission by the Department of Social Protection, it is evident that Grace was paid the following during the period from 23rd September, 1996 to 22nd July, 2009:

Allowance	Year	Date From	Date To	Weeks	Weekly Payment	Initial / Christmas Bonus	Gross / Total	Year
DPMA	1996	23/09/1996	01/10/1996	1	€ 81.89	€ 27.30	€ 109.19	1996
DA	1996	02/10/1996	31/12/1996	13	€ 81.89	€ 57.39	€ 1,121.96	1996
DA	1997	01/01/1997	06/01/1998	40	€ 81.89		€ 4,364.18	1997
				12	€ 85.71	€ 60.06		
DA	1998	07/01/1998	05/01/1999	40	€ 85.71		€ 4,565.37	1998
				12	€ 89.52	€ 62.73		
DA	1999	06/01/1999	04/01/2000	39	€ 89.52		€ 4,769.96	1999
				13	€ 93.33	€ 65.39		
DA	2000	05/01/2000	02/01/2001	40	€ 93.33		€ 5,012.40	2000
				12	€ 98.40	€ 98.40		
DA	2001	03/01/2001	01/01/2002	13	€ 98.40		€ 5,621.60	2001
				39	€ 108.56	€ 108.56		
DA	2002	02/01/2002	07/01/2003	52	€ 118.80	€ 118.80	€ 6,296.40	2002
DA	2003	08/01/2003	06/01/2004	52	€ 124.80	€ 124.80	€ 6,614.40	2003
DA	2004	07/01/2004	04/01/2005	52	€ 134.80	€ 134.80	€ 7,144.40	2004
DA	2005	05/01/2005	03/01/2006	52	€ 148.80	€ 148.80	€ 7,886.40	2005
DA	2006	04/01/2006	02/01/2007	52	€ 165.80	€ 165.80	€ 8,787.40	2006
DA	2007	03/01/2007	01/01/2008	52	€ 185.80	€ 185.80	€ 9,847.40	2007
DA	2008	02/01/2008	06/01/2009	52	€ 197.80	€ 197.80	€ 10,483.40	2008
DA	2009	07/01/2009	22/07/2009	30	€ 204.30		€ 6,129.00	2009
							€ 88,753.46	

3.20 The Commission calculated the payments made to Grace during the period of 12 years and 9 months while she was in the care of Family X, either by way of DPMA or Disability Allowance, to be €88,753.46 in total.

3.21 When giving evidence to the Commission, Ms Conroy said that, having regard to the documentation, there was nothing historically in the period up until 2009 that gave her any cause for concern or which gave any cause for investigation by the

Department regarding the administration of the payments or of the appropriateness of the payments to Grace.

Payment of Grace's Disability Allowance

Method of Payment

3.22 The relevant legislative provisions relating to payment of DPMA/ Disability Allowance during the period the subject of this Chapter were as follows:

- **1998 to 2005:** Part VI of the Social Welfare (Consolidation) Act, 1993 as amended; and Chapter 2 of Part VI of the Social Welfare (Consolidated Payments Provisions) Regulations 1994 (S.I. No. 417 of 1994) as amended;
- **2006:** Part 9 of the Social Welfare Consolidation Act, 2005; and Chapter 2 of Part VI of the Social Welfare (Consolidated Payments Provisions) Regulations 1994 (S.I. No. 417 of 1994) as amended.
- **2007-2009:** Part 9 of the Social Welfare Consolidation Act, 2005; and Chapter 2 of Part 7 of the Social Welfare (Consolidated Claims, Payments and Control) Regulations 2007 (S.I. No.142 of 2007) as amended.

3.23 Both Chapter 2 of Part VI of the Social Welfare (Consolidated Payments Provisions) Regulations 1994 and Chapter 2 of Part 7 of the Social Welfare (Consolidated Claims, Payments and Control) Regulations 2007 allowed for the payment of DPMA/ Disability Allowance by way of the following:

- (a) an order payable at a post office;
- (b) a cheque issued by post;
- (c) direct credit transfer to a bank account;
- (d) in cash payable at a Post Office;⁵
- (e) an order payable at a bank; and

⁵ Chapter 2 of Part VI of the Social Welfare (Consolidated Payments Provisions) Regulations 1994 also allowed for a cash payment to be made at a local social welfare office.

- (f) such other manner as the Minister may arrange where the circumstances warrant it.

3.24 Ms Conroy told the Commission that, in recent years, there had been a decline in the number of people receiving their social protection payments in cash in the post office and an increase in electronic payments into customers' banks. This was happening across all schemes and not just for Disability Allowance, she said. However, at the time of giving her evidence, she indicated that 43 *per cent* of these payments were still being made through the post office.

3.25 Ms Conroy said that there was provision in the Disability Allowance Scheme for agents to collect payments, for instance, in the post office, on behalf of individuals who might not be in a position to do so themselves because of their disability. She described the operation of two types of arrangements involving agents who would collect the payment on behalf of the individual, namely, arrangements in respect of "Type 1 Agents" and "Type 2 Agents". These agency arrangements are reported upon below.

Guidelines on payment-related issues

Agents

3.26 Departmental guidelines on payment-related issues dating from 1998 to 2008 (the "Guidelines"), which were used by the Department to help staff to assess claims, entitlements and benefits, and which were in effect during the period the subject of examination of this Chapter, provided as follows:

"APPOINTMENT OF AGENTS"

For the purposes of this note quote 'Agent' means a person other than the person eligible to receive a payment who is appointed, either temporarily or on a long- term basis, to collect payments on behalf of a claimant. There are two types of agents appointed by the Department, referred to as type '1' agent and type '2' agent. Each type of agent has its own responsibilities and functions..."

3.27 A Type 1 Agent was authorised to collect a payment on behalf of a claimant who was unable to collect the payment in person due, for instance, to illness or loss of mobility. These agents are not relevant for the purpose of this Chapter.

3.28 With regard to Type 2 Agents specifically, the Guidelines provided as follows:

“This type of agent may be appointed in cases where a person is permanently unable to act e.g. where s/he is not in a position to discharge her/his responsibilities - usually due to mental infirmity. In this type of situation, a formal application must be made on behalf of the incapacitated person and documentary evidence provided showing the extent of the inability of the person to act. This evidence may be in the form of a High Court Order deeming the person to be a Ward of Court, medical evidence and/or a report from a Social Welfare Inspector of the Department on the circumstances of the case.

Where this type of agent is appointed the agent is responsible for ensuring that the payment is used for the benefit of the claimant and reporting any changes in the claimant's circumstances as required under social welfare legislation e.g. increase in income/means, change in circumstances of any dependants for whom an increase in payment is being made.

This agency arrangement may also be withdrawn at any time by the Department where it has reason to believe that the payment is not being used for the benefit of the claimant. If this occurs, the agent must, where appropriate, return the payable order book on request...”
(emphasis added).

3.29 The Guidelines prescribed the methods by which payments could be made by the Department. These included use of electronic fund transfers, electronic information transfers (“EIT”) (with the person entitled, or agent, attending at a post office with a social services card to collect the payment), personalised payable orders (“PPOs”), post drafts and cheques.

- 3.30 It appears from the evidence before the Commission that the use of a Personalised Payable Order Book ("PPO Book") was the method by which Grace's Disability Allowance was paid and collected. PPOs were issued by way of a book once or twice a year. This book was cashable weekly at a nominated post office. The PPO had to be signed at the post office of payment in the presence of the post office counter staff.
- 3.31 With regard to the appointment of a Type 2 Agent for the purpose of encashment of a PPO Book, the Guidelines required a formal application to be made, using application forms available from the Department or post office. The Guidelines provided that the following were to be included with the application:
- claim number;
 - name and address of the customer;
 - signature of the customer or, where the customer was unable to sign, his/her mark to be witnessed;
 - name and address of the proposed agent;
 - signature of the proposed agent;
 - reason why appointment of agent was required;
 - name of the required post office of payment; and
 - medical evidence, as required.
- 3.32 The PPO Book also needed to be returned to the Department with the request for appointment of the Type 2 Agent. Once the Department was satisfied that the request was in order, the application was processed and a new PPO Book was issued to the nominated post office.
- 3.33 In all other cases not involving PPOs or electronic fund transfers, a formal application was also required for the appointment of a Type 2 Agent. This application needed to be in writing and to include the information listed above (other the name of the nominated post office). In the case of electronic fund transfer, details of any new

banking arrangements were required. Once the Department was satisfied that the request for an agent was in order, the application was processed, the agent was appointed and the agent was notified of the payment arrangements.⁶

- 3.34 Later departmental guidelines that were issued after Grace had been moved into a residential placement in July, 2009 contained more detailed provisions with regard to the permitted age of the Type 2 Agent and the categories of persons who could be appointed as a Type 2 Agent or were disqualified from being so appointed. Those later guidelines also contained considerably more detail with respect to the Type 2 Agent's responsibilities and duty of care to the claimant/customer and the manner in which Disability Allowance was to be spent and managed. For instance, they included a requirement to lodge the balance of the Disability Allowance payment to an interest-bearing account for the benefit of the customer, as well as a requirement to keep a record of all sums received and all transactions made in relation to the payment. Those later, more detailed, guidelines had no application, however, during the period the subject of this Chapter.
- 3.35 In giving her evidence on these arrangements, Ms Conroy referred specifically to the Department's *"Guideline on Payment Related Issues"* dated 13th November, 2018 ("the 2018 Guidelines"), which set out in practical detail the arrangements for an agent to collect State social protection payments (including Disability Allowance) in the appropriate circumstances, as well as the duties and responsibilities of Type 2 Agents. The 2018 Guidelines had no application during the period that Grace was placed with Family X and during which Mrs. X collected Disability Allowance payments on Grace's behalf.
- 3.36 As reported below, Mrs. X was appointed as Grace's Type 2 Agent with effect from 1st November, 2006. There was no evidence to the Commission to indicate that the operative Guidelines with regard to her responsibilities as a Type 2 Agent were brought to her attention over the period that she collected Grace's Disability Allowance.

4. Mrs. X as Type 2 Agent

⁶ Departmental guidelines relating to Payment-Related Issues issued in 1998, 1999, 2000, 2003, 2004 (June), 2004 (August), 2005, 2006, 2007 and 2008. The above requirements relating to the appointment of the Type 2 Agent contained in the Guidelines were not altered throughout the period from 1998 to 2008.

- 4.1 Ms Conroy gave evidence concerning the application made by Mrs. X to be duly appointed to collect Grace's Disability Allowance at the local post office, a copy of which application was disclosed to the Commission.⁷
- 4.2 The application included two forms. One of those forms was entitled "*Application Form for Authority to Collect Payment through an Agent*"⁸ and was dated 23rd October, 2006. This form was only to be completed in respect of customers who were being paid by way of PPO. The reason given in the completed form for the appointment of an agent was "*disabled*" and "[Grace] *is mentally [and] physically handicapped. Unable to speak...I am her Carer 24/7 so I will collect and sign for her Disability Allowance every week at [name of village in South East] [post office]. Thank[s]*" The customer signature part of the form was signed by Mrs. X and witnessed by Mrs. X. The form was also signed by Mrs. X as "*proposed agent*". This application form did not reference the responsibilities of a Type 2 Agent.
- 4.3 The other form completed by Mrs. X as part of this application was entitled "*Application for Standing Authority to Collect Pension/Allowance through an Agent*". This was a form to be used when the beneficiary was incapacitated and was certified to be unable to attend at the post office for at least four weeks. The form was dated 26th October, 2006. The copy of the form furnished to the Commission bore a handwritten endorsement which read, "[a]s [Grace] *is unable to sign for herself please complete this form and have it signed + STAMPED by a doctor*".
- 4.4 The form stated: "*I hereby apply to have [Mrs. X] residing at [address] duly appointed to collect it on my behalf from time to time as it becomes due at [village in South East] Post Office.*" The form was marked rather than signed and it was witnessed by Mrs. X. The form stated "*I agree to act as agent for the above-named pensioner/beneficiary*" and it was signed by Mrs. X as "*proposed agent*". The application form did not reference the responsibilities of a Type 2 Agent.
- 4.5 A form of medical certificate attached to the enclosed application form was subsequently completed by Dr. G (Grace's general practitioner at that time) on 31st October, 2006. This certified that Grace was incapacitated and unable to attend the post office to collect her Disability Allowance by reason of "*mental handicap*".

⁷ The Social Welfare Offices form (Form IA7) is entitled "*Application form for Authority to Collect Payment through an agent*".

⁸ Social Welfare Services Office Form IA 7.

- 4.6 Dr. G did not recall completing the certificate. At the time that he signed it, he had not yet met Grace. While she was a patient of the practice, he said, she was not his patient.⁹ He gave evidence that, while it later became the practice for him to copy and file a certificate such as this, he did not do that back in 2006. He told the Commission, “[g]enerally what would have happened is that someone would have given me this form to sign and I would have just signed it and stamped it”. With regard to the certification by him, he said “generally you would know from the notes, or you would be told, it wouldn’t be documented”. He had no recollection of consulting notes or of the circumstances in which he gave the certificate.
- 4.7 In terms of the application form itself, Dr. G told the Commission that the only thing that he would look at would be just that “the medical certificate is that she is incapacitated and attended.”
- 4.8 Notwithstanding the requirement in the Guidelines that “a formal application must be made on behalf of the incapacitated person and documentary evidence provided showing the extent of the inability of the person to act”, there was no documentation available from the Department with respect to any application by Mrs. X to act as agent for Grace for the period prior to this application in 2006.
- 4.9 However, the Commission is satisfied that Mrs. X collected DPMA initially and then Disability Allowance on Grace’s behalf from the post office from the time that this became payable to Grace in 1996.
- 4.10 Mrs. X was approved as a Type 2 Agent for Grace with effect from 1st November, 2006.

Finding

- 4.11 As noted above, there was nothing historically in the documentation relating to the period up until 2009 that gave Ms Conroy any cause for concern or gave any cause for investigation by the Department of the payments or of the appropriateness of the payments to Grace. The fact of the collection of Grace’s Disability Allowance by Mrs.

⁹ As reported upon in Chapter 3 of this Volume, Grace was a patient of the practice run by Dr. G’s father, Dr. F, and was seen occasionally by both Dr. F and Dr. G during the time she resided with Family X.

X over the period considered is not, of itself, a matter of concern. It is the issue as to how Mrs. X managed Grace's Disability Allowance that is the focus of the Commission's considerations.

Type 2 Agent responsibilities

- 4.12 Pursuant to the Guidelines, the extent of Mrs. X's responsibilities in terms of the management of Grace's DPMA and, latterly, her Disability Allowance, were as follows:

"the agent is responsible for ensuring that the payment is used for the benefit of the claimant and reporting any changes in the claimant's circumstances as required under social welfare legislation e.g. increase in income/means, change in circumstances of any dependants for whom an increase in payment is being made."

Separate bank account

- 4.13 Mrs. X told the Commission that she collected Grace's Disability Allowance in cash from the post office. She did not open a separate account for any balance of the Disability Allowance for the benefit of Grace and instead *"put any money together...[a]nd got the shopping, got everything together."* During her evidence, she agreed that it all went into *"one pot"*.
- 4.14 On the evidence to the Commission, the issue of a bank account was first raised with Mrs. X during the home visit which Mr. Smith and Ms Griffin made to Mrs. X on 13th September, 2007. On the evidence to the Commission, this was the first time that any question with respect to the management of Grace's Disability Allowance had been raised with Mrs. X. In his note of the visit, Mr. Smith recorded that he asked about Grace's Disability Allowance and that Mrs. X said that this was used to pay for the day centre (Day Service Provider A) and to buy clothes and *"whatever [Grace] wants really"*. Mr. Smith noted that he asked if any of the Disability Allowance was put into a separate account for Grace and that Mrs. X had replied, *"the social worker never told me to do that"*. However, she told him that she would do so, if that was what was needed.

Bank account in Grace's own name

- 4.15 Ms B's note of a Person-Centred Plan ("PCP") meeting held in respect of Grace on 3rd July, 2009¹⁰ recorded as follows:

"When asked about management of [Grace's] finances, [Mrs. X] stated that [Grace] does not have her own bank account and that [Mrs. X] manages her money for her. [Mrs. X] stated that she puts money aside for [Grace] herself. [Mrs. X] was asked to set up a bank account for [Grace]."

- 4.16 In her handwritten notes of the PCP meeting, Ms B recorded:

"[Mrs. X] was asked whether [Grace] has a bank [account]. [Mrs. X] said that she doesn't. Staff advised [Mrs. X] that it would be preferable for [Grace] to have a bank [account] so that she could manage her money transparently - also asked [Mrs. X] re: save [Grace's] money. [Mrs. X] stated that she saves some money on [Grace's] behalf & spends the rest on [Grace]."

- 4.17 Regarding Mrs. X's grandson's (Alpha's) finances, Ms B's note of the PCP meeting read as follows:

"[Mrs. X] stated that he usually gives her his wages and she gives him some money but they had an argument recently because [Alpha] had gone to town and bought tickets for a concert and spent all of his money. [Alpha] had also lent money to a friend to buy a ticket. [Mrs. X] stated she was very annoyed about this."

- 4.18 Ms Caroline Burke, who was an Independent Advocate assigned to Grace and who also attended the meeting, made a similar note which read: "[Mrs. X] also spoke about her grandson and money and tickets for the 'big day out' that he got for his birthday".

¹⁰ The PCP meeting was held in Day Service Provider A and was attended by Ms B, Ms D, CW6, Ms Caroline Burke (Independent Advocate), and Mrs. X.

- 4.19 Regarding the issue of opening a bank account for Grace, Ms Burke noted as follows:

"[Ms B] asked about [Grace's] access to money and savings. [Mrs. X] advised that [Grace] has money but that she does not have a bank account. [Mrs. X] looks after her money for her. [Mrs. X] advised that she might look at a credit union account for [Grace] in the future."

- 4.20 When she was asked during her evidence if she remembered this part of the discussion, Ms D said: *"I remember a discussion about money because the meeting was very, very planned."* Ms D added:

"I remember clearly there was a plan that [Grace's] money would be brought up and about a bank account. At that point as well it wouldn't have been only [Grace] who didn't have a bank account and we would have been advocating for all service users to have personal bank accounts."

- 4.21 Ms D agreed that raising the need for a bank account for Grace at the PCP meeting might have been connected to preparations for Grace's move to the residential placement, but she said that she did not recall that being *"a specific purpose"*.

- 4.22 Ms D said that Day Service Provider A had a number of service users at that time whose intellectual disability was not as profound as Grace's and who were in employment for a certain number of hours *per* week and did not have bank accounts in their own names. Ms D said that it was *"just an area of work that we [were] working on within the service to give people more responsibility over their finances and their own money."*

- 4.23 Ms D said that there were service users who lived at home and whose parents would manage their social welfare allowances. She said, however, that the distinction between those people and Grace was that *"for those people or for most or a lot of those people we wouldn't have had concerns in relation to their presentation. They didn't come in in the unkempt state that [Grace] was coming in to us."* Regarding Grace's finances, Ms D said that the issue was that *"there was Disability Allowance being paid and we would have had concerns that that money wasn't going to [Grace] for her benefit."*

- 4.24 Regarding those service users whose parents were managing their allowances or where the allowances were *“going into a central pot”* and in respect of which Ms D said that Day Service Provider A did not have concerns, Ms D said that there were *“no concerns that the people were being neglected in any way or that they didn’t have access to things that they actually wanted...That money was still being used for their benefit even if they didn’t have direct responsibility for it themselves.”*
- 4.25 For those service users for whom Day Service Provider A did not have these types of concerns, Ms D said that the need to open a bank account *“wasn’t a particular concern, it was something that we would just advocate for people to have as much responsibility as what is feasible for them and safe for them”* and because it *“fostered personal responsibility”*.
- 4.26 Ms D said that there were cases of service users’ allowances being put into a central *“pot”* to be used to discharge family expenses while, in other cases, Disability Allowance would be placed in a service user’s bank account and *“never touched”*, with the person being *“cared for by the parents’ finances.”* She said that, as a matter of practicality, there was a variety of ways in which parents would deal with the issue of their children’s finances. Leaving aside the question of personal responsibility, Ms D said that once Day Service Provider A did not have concerns about service users’ presentation, their finances were not an area that Day Service Provider A needed to get involved in, unless a service user raised the matter or *“wanted support”*.
- 4.27 Ms B said during her evidence that her preliminary view was that Mrs. X did not want to put part of Grace’s Disability Allowance towards paying to have Grace’s hair cut (a matter reported upon below) and that this added to concerns that the staff in Day Service Provider A already had in relation to Grace’s finances. Regarding the existing concerns that Ms B spoke about, she outlined how there was no real indication that Grace’s Disability Allowance was spent for her benefit. Added to this, she said that Mrs. X had now confirmed to them that Grace did not have a bank account in her own name and that she simply *“put their money together”*.
- 4.28 Similar to Ms D, Ms B’s evidence was that the issue of opening bank accounts arose in Day Service Provider A in the context of a campaign they had started of promoting independence and educating service users on how to manage their money, or if they had a concern in relation to a person’s access to their Disability Allowance. Ms B told the Commission that *“across the board”* it was *“quite common practice”* at that time

(2009) for people with disabilities to have their payments collected from the post office by a Type 2 Agent from within their family and that it would be kept in cash, as distinct from a bank account.

4.29 Ms B said that they encountered difficulty with financial institutions in setting up bank accounts for people who lacked capacity and that that continued to be the case. She thought this might have been why they asked Mrs. X to arrange to open a credit union account for Grace. In this regard, Ms B said that, even after Grace moved into the residential placement, it had not been possible for her to have a credit union account opened in her own name because she was not capable of going into the credit union and asking to take money out, which was a particular requirement of the credit union.

4.30 Ms B's evidence was that, in 2009, in the majority of cases where social welfare payments were collected for a service user, the payments were used for the service user's benefit and that, "*by and large*", service users were not expected to contribute to the household. Ms B said that, very often, service users would have "*quite a significant amount of money*" (if they had their own bank account) or else access to a lot of money, particularly if they had a job.

4.31 Ms B said: "*[I]n fact we would actually find that a lot of those service users were not expected to contribute generally to the household; the money might have been collected but they actually enjoyed a standard of life that was well above € 188 a week of activities, and things like that.*"

4.32 With regard to Grace, Ms B said:

"[Grace] would have been one of the very few that we were actually concerned that she wasn't enjoying the benefit of her Disability Allowance; that wouldn't have been the case with other families where they were collecting the payments in cash."

4.33 Ms B agreed that, as a matter of practicality at that particular time, although Day Service Provider A was trying to set up a more structured system, the reality was that carers were collecting social welfare benefits on behalf of the people that they were

caring for and managing the money as they saw fit. She did not know how many service users they had assisted in setting up accounts by this time, as she said that they would only have discussed it if there was *“a concern or a reason to broach the financial aspect of it”*.

- 4.34 In her evidence, Mrs. X initially said that she did not remember the PCP meeting on 3rd July, 2009. When looking at the notes of the meeting, she said that all she could recall was the discussion about “[Grace’s] *taking off her clothes*” and about what Mr. McGovern had told her. Later in her evidence, she said that the only detail from Ms B’s note of the PCP meeting that she could recall was *“...the hair.”* The discussion about opening a bank account for Grace was not something that she recalled.
- 4.35 Regarding the opening of a bank account on behalf of recipients of Disability Allowance, Ms Conroy confirmed to the Commission that *“[w]e don’t have a necessity for the person to open a bank account, but if they do decide to open one, we would help facilitate the opening of one, in the client’s name (not agent), but as I said it’s not a necessity.”*¹¹ Ms Conroy subsequently confirmed to the Commission that the *“Department does not help facilitate the opening of a bank account. That would be a matter between the person themselves and their bank.”*
- 4.36 It became clear to the Commission that, when endeavouring to open a bank account for Grace in 2009, the staff of the local voluntary association encountered difficulty in doing so, due to requirements to do with identification and anti-money laundering legislation. However, they did ultimately manage to open a bank account for Grace in September, 2009.

Findings

- 4.37 The Commission cannot be satisfied that the opening of an interest-bearing bank account for any balance of Disability Allowance not spent for the benefit of or in the best interests of the person entitled to it (“the customer”) was in fact a practice that was widely adhered to throughout the period that Mrs. X collected Grace’s Disability Allowance.

¹¹ Garda statement made by Ms Conroy, 15th July, 2019.

- 4.38 The evidence to the Commission did not establish that there was a requirement to lodge Grace's Disability Allowance to an interest-bearing bank account in Grace's own name with an accruing balance at the time that Mrs. X was appointed a Type 2 Agent or during the time that she collected Grace's Disability Allowance from 1996 to 2009. The extent of Mrs. X's obligations pursuant to the Guidelines was to ensure that the Disability Allowance payment was used "*for the benefit of*" Grace and to report any changes in the Grace's circumstances, as required under social welfare legislation.
- 4.39 There was no requirement under the Guidelines in effect in 2007 that the balance of Grace's Disability Allowance be placed in a separate account.
- 4.40 The fact that no such bank account was opened over the years during which Mrs. X collected Grace's Disability Allowance, did not, of itself, establish financial abuse.
- 4.41 The issue for inquiry by the Commission was as to how Grace's Disability Allowance was, in fact, applied or spent by Mrs. X and as to whether the allowance was, in fact, used by Mrs. X for Grace's benefit.
- 4.42 In this regard, the Commission is satisfied that Mrs. X, as agent for Grace, was entitled to apply Grace's Disability Allowance towards Grace's legitimate household and living expenses. Thus the allowance could reasonably be spent on items such as Grace's food and groceries, her clothing, shoes, toiletries, contributions to utilities, accommodation costs, cost of attendance at Day Service Provider A, occasional meals out, and other incidentals that Grace might require. Discretionary expenditure from the allowance on any other matters that inured to Grace's benefit, was clearly permissible, with the unspent balance to be held for Grace.

5. Manner in which Grace's DPMA / Disability Allowance was spent - up to July, 2009

Preliminary

- 5.1 The Commission's focus was on establishing the facts as to whether Grace's money was applied by Mrs. X on Grace's behalf and for her benefit. The manner in which Grace's Disability Allowance was to be spent was, as a matter of reality, a matter to be determined by Mrs. X as agent in circumstances where Grace did not have the capacity to determine her living conditions or choose how it would be spent. In this

regard, Grace could not express any preferences or desires for particular possessions or activities or expenditure on her own personal care.

- 5.2 When she was asked in evidence if she had ever abused or mistreated Grace in terms of her finances, Mrs. X said that she had, going on to refer to the fact that *"I put her money and my money together and when she left I only had € 1,300 [of savings] to give her and I sent it to [Ms B]."* She said that she had failed to save money for Grace prior to Mr. Smith's mentioning the need to do so. It is of note, however, that Mrs. X said that she had not perceived this at the time as being *"unfair"* and that she had done as Ms Greaney had told her to do, saying *"she told me whatever money would come, it would be between us..."*
- 5.3 Asked why she had not put money aside for Grace prior to Mr. Smith's mentioning it to her in August, 2007, Mrs. X replied *"[b]ecause I put it with mine...[b]ecause I bought the shopping."* She said that she ran the household from the social welfare payments that she collected from the post office. The matter of Mrs. X's making a payment to Ms B is reported upon in Section 6 below.
- 5.4 In terms of Mrs. X's and Grace's respective social welfare allowances, Mrs. X said that *"I put mine and hers together and I done the [household] shopping with it"*. Her evidence was that she did the shopping for the household, saying that this was enough shopping to cover whoever happened to be in the household at any given time.
- 5.5 As has been reported upon above, the fact that Mrs. X did not lodge Grace's allowance in a bank account in Grace's own name was not an uncommon practice at the time. Neither that feature, nor the pooling of Grace's and Mrs. X's allowances, were factors that necessarily amounted to abuse in and of themselves. What was critical to determine in establishing if there had been financial abuse of Grace was how Grace's allowance was spent.
- 5.6 Mrs. X did not keep a record over the years of how she spent Grace's Disability Allowance, as the allowance was simply subsumed into the household budget. Such evidence as was available to the Commission with regard to expenditure from Grace's allowance was quite generalised in the circumstances. With respect to day-to-day expenses, for example, it was therefore not possible or practicable to establish, with any degree of accuracy, the precise extent to which items from food

and grocery shopping could be identified as items purchased primarily for Grace's benefit over the years that she lived with Family X. The Commission considers that any attempt at such calculations for almost a 13 year period would, in the absence of records of expenditure, be artificial and unreliable.

- 5.7 Aside from day-to-day expenses, insofar as household bills and expenses were concerned, these were not broken down or calculated in a manner that earmarked a proportion of bills as applying solely to Grace or as representing a proportion of services or utilities applied to her benefit. The Commission considers, again, that any attempt at such calculations at this stage for a period spanning almost 13 years would, in the absence of records of expenditure, be artificial and unreliable.
- 5.8 In her evidence, Mrs. X also did not calculate or attribute any portion of monies from Grace's allowance as having been applied as a rental payment. The reality of the situation was that Mrs. X viewed Grace as part of the household, and simply subsumed Grace's Disability Allowance into the household budget. She did not keep any account or retain a balance of monies not expended for Grace's benefit, on Grace's behalf.

Grace's clothing

- 5.9 The matter of Grace's clothing has been examined in detail in Chapter 3 of this Volume in the Section dealing with her presentation. That Chapter should be read in conjunction with this one.
- 5.10 As reported in Chapter 3 of this Volume, Mrs. X said that she bought Grace's clothes in various different shops in a nearby provincial town.
- 5.11 Mrs. X said that when she bought Grace new clothes or shoes, Grace would "*rip them off*" and would not wear them. She said "*[y]ou might find it difficult to believe that, but that did happen all the time. She didn't want anything new, just like the keys. I could give her anything but she wouldn't take it.*" Mrs. X's evidence was that she did not stop buying new clothes for Grace, even though she ripped them. Mrs. X said

that Grace removed her new shoes all of the time. She said she knew that Grace liked to wear tracksuit pants and that she constantly bought new tracksuit pants for her, as Grace was less likely to rip them than other clothing. She said that Grace was comfortable in old clothes.

- 5.12 A number of the Commission's findings, as contained in Chapter 3 of this Volume are set out below, for ease of reference:

"5.280 As Grace's carer, Mrs. X was the person who provided Grace's clothing. These were funded from the foster care allowance/children's allowance when Grace was in foster care, and thereafter from Grace's Disability Allowance. If Grace's clothing had once been purchased as new, by the time she began to attend the day centre in 1995 her clothes appeared well used and were seen as dated by some members of staff. It is a reasonable inference from the evidence that, in all likelihood, Grace wore some clothes that she had had in earlier years well into adulthood, or that clothing purchased was of a second-hand variety. The evidence to the Commission indicated that Grace's style of clothing did not change over time and that there was no appreciable difference between the style of her dress as a child and as an adult.

5.281 The evidence established that Grace's clothes were functional for her day-to-day activities. The type of clothing worn was influenced by what was practical and comfortable in terms of dressing and undressing, a task with which Grace always required assistance. Grace often wore tracksuit bottoms. Her clothes sometimes needed to be changed during the day, due to her incontinence, and also for swimming activities and for showers or baths in Day Service Provider A.

5.282 Mrs. X's account of often buying new clothes for Grace was not supported by the evidence of their appearance as observed at her day placement. Mrs. X's evidence was vague and contradictory on this matter and the Commission cannot accept it as correct.

5.283 Mrs. X maintained in her evidence that there was nothing unsuitable or substandard about the style of clothes that Grace wore. On the contrary, Mrs. X considered that she dressed Grace well in clothes such as pants, jumpers and runners, describing her as the “best dressed girl on the bus”. The Commission is not satisfied, however, that her view of Grace’s standard of clothing was borne out by the totality of the evidence on this issue. Mrs. X’s evidence on the issue was accompanied by the assertion that she always bought new clothes for Grace. The fact that this was incorrect, in itself, undermined Mrs. X’s assertion as to the standard of Grace’s clothes.

5.284 The question as to whether the type or standard of the clothes in which Grace was dressed over the years was such as to raise a concern that she was neglected, is a particularly subjective one. This was amply demonstrated through the evidence of Mr. M and that of other witnesses reported in this Chapter. As already reported, by 2001 (before Grace’s case slipped from view), no issue regarding the manner in which Grace was dressed had ever been raised with Mrs. X by SEHB/HSE personnel involved in her case.

5.285 With respect to the differences in the evidence that emanated from Day Service Provider A personnel concerning Grace’s presentation, broadly relating to the period up to 2007, the Commission accepts that Mr. M’s evidence about Grace at Day Service Provider A was a true reflection of his views and perspective over that time about how she appeared and her presentation in the day centre. The Commission also accepts that the evidence given by a number of the care staff who worked with Grace reflected their views on how she presented at the day centre over that time.

5.286 However, with respect to the difference in the evidence of Mr. M and some of the care staff as to the condition or suitability of Grace’s clothing, the Commission notes that the care staff were engaged more closely with Grace’s personal care needs and accordingly were more focused on the quality and condition of her clothing and her presentation. The Commission accepts their recollections of the standard and condition of Grace’s clothing and is satisfied that the

descriptions of her clothes as old-fashioned, with an old or worn appearance at times and being of a basic variety, were substantially accurate. Further, the difference in Grace's presentation by virtue of her style of clothing, which was of inferior quality to that of some of the other service users, was noticed by several members of staff in the day centre. The description of some witnesses of Grace's clothes as ill-fitting, however, was not a feature that was reported consistently in the evidence provided and it was not clearly established from the evidence that this was generally the case.

5.287 The Commission also accepts that Mr. M's view that Grace's clothing was suitable for her activities in Day Service Provider A (or as Mr. M said, "sufficient unto the day") was genuinely held and correct in itself. As manager of Day Service Provider A, Mr. M's main focus was on Grace's benefiting from the activities available to her there. He did not particularly take account of her clothing style. Insofar as he did, the Commission is satisfied that Mr. M did not consider her clothing to be unsuitable and this did not give rise to his having any concern for Grace's welfare or that she was neglected. However, to the care staff whose role it was to tend to Grace's personal care and to Ms D and Ms B who encountered her later in 2008, the quality of her clothing appeared to be poor and of a basic standard. The Commission is satisfied on the evidence that these members of staff at Day Service Provider A had closer contact with Grace and a better opportunity to observe the quality and condition of her clothing.

5.288 The fact that Grace could not express any view on her own appearance meant that the style and quality of the clothes that she wore were chosen by Mrs. X. The Commission notes that Mrs. X herself dressed in an ordinary fashion and in a practical manner for day-to-day life in the countryside. The totality of the evidence suggested that Mrs. X made do and expended little on Grace's clothing. The Commission is satisfied that, in all likelihood, this was more and more the case as the years advanced.

5.289 The Commission accepts that Mrs. X's grandson and her nephew did not regard the standard or style of Grace's clothing as in

any way deficient. This was not out of any disregard for Grace; rather they both considered Grace to be well looked after by Mrs. X and did not find fault with the type or standard of her dress or the manner in which Mrs. X managed her care.”

- 5.13 Having regard to the above findings and the evidence upon which they are founded, the Commission considers it unlikely on the evidence that a substantial portion of Grace’s Disability Allowance was expended on clothes or shoes for her. However, notwithstanding the basic variety of Grace’s attire, in all likelihood, modest sums were expended on her behalf by Mrs. X on items of clothing from time to time over the approximately 13 years that Grace was entitled to a Disability Allowance while living with Family X.

Other purchases

- 5.14 Other than buying her clothes, Mrs. X said that she gave Grace “*anything she wanted*” and gave as an example having bought her a bicycle. Mrs. X also said that she sent in a tricycle to Day Service Provider A. However, Mr. M’s recollection was that Mrs. X did not do so, because he knew that the tricycle donated to the day centre had come from neighbours of his. He recalled that the neighbours did not want it anymore and the father of the girl whose it was had fixed it up and brought it into Day Service Provider A. Mr. M said that if, Mrs. X had brought it in, it would have meant that there were two tricycles, which he never saw and for which the day centre would not have had space. The Commission is satisfied that Mr. M’s recollection as to the origin of the tricycle in Day Service Provider A was more reliable than Mrs. X’s account and that his evidence is correct. Whether or not there was a tricycle for Grace’s use at home, the Commission is not satisfied that Mrs. X’s evidence to the effect that she had sent a tricycle into Day Service Provider A was accurate or correct.
- 5.15 When asked what she meant when she had stated that she gave Grace anything she wanted, Mrs. X had difficulty in giving examples to the Commission of what she was referring to and went on to say that Grace only wanted her plastic keys and that she would not take anything else. She said Grace did not want the toys that she said she bought her. In this regard, Mrs. X said: “*[w]e bought her teddy bears, dolls, people bought her presents, she’d throw them on the floor. Everything was thrown. New*

shoes, thrown." At the time of the Commission's inspection in 2019, there were still some old stuffed toys in the house.

- 5.16 Mrs. X said that she could not think what she had bought for Grace after she turned 18 years of age, other than clothes and that Grace was not interested in anything else. She said that "*those material things*" meant "*nothing*" to Grace.
- 5.17 There was no evidence to the Commission of Grace having accumulated material objects or personal belongings (outside of her clothing) of any significance over the time that she lived with Family X. As with all issues investigated by the Commission, the voice of Grace is absent from the evidence. However, and taking account of Grace's level of disability, there was also no evidence of Grace's having indicated a desire or preference for particular items of personal property. The evidence to the Commission from persons, other than Mrs. X, did not purport to identify any particular items (outside of items such as clothing, related to Grace's personal care) as having been denied to Grace. The Commission found that, on the totality of the evidence with respect to Grace, both in her placement with Family X and in Day Service Provider A, Grace did not display any interest in material objects or possessions. While Grace was unable to express a desire for particular material items, the fact that greater investment in such items, her physical environment, and in her well-being may have resulted in positive outcomes for her certainly cannot be excluded.
- 5.18 Insofar as the expenditure on Grace from her Disability Allowance is accounted for, the Commission is, therefore, satisfied overall that there was little expenditure on material possessions for her.

Grace's belongings in July, 2009

- 5.19 Grace was removed from Mrs. X's care on 17th July, 2009 and this is a matter reported upon in Chapter 20 of Part 2 of Volume 1. Mrs. X was not made aware of the move occurring on that day until after it had happened, as Grace was taken directly from Day Service Provider A to her new residential placement. Grace, therefore, arrived at her new residential setting without any belongings, save for her plastic keys from which she was rarely separated.
- 5.20 Subsequent to Grace's move to the residential placement, Ms B made a note on 19th August, 2009 that she had been informed by CW6 that two brown cardboard boxes

had been left in the porch area of Day Service Provider A with Grace's name on each box. Ms B noted that she and CW6 took the two boxes into Day Service Provider A and opened them. Ms B noted that the boxes contained clothes and underwear. She recorded that there was a "*strong odour*" coming from the clothes and that three garments were "*noticeably stained*."

- 5.21 Ms B told the Commission that she and the other staff at the local voluntary association were familiar with some of Grace's clothes contained in the boxes, but that there were others which she had not seen before. She said that they were in "*a variety of sizes and in a variety of conditions*." In particular, Ms B recalled that some of the items of underwear included in the boxes were "*clearly newly purchased but opened*" and, although removed from their packaging, still had the cardboard inserts of the packaging in them. Ms B recalled that some of these new items of underwear were also the wrong size for Grace, some being a size 14, whereas she said that Grace would have been a size 6 to 8 at the time.
- 5.22 Some of the other items of clothing were stained or dirty. Ms B thought it was unlikely that Grace was going to wear many of the clothes. She had had a lot of clothes purchased for her in the intervening time, which, according to Ms B, were in much better condition and much more suited to her. Ms B said that she was keen to keep the clothing that had been delivered in the boxes, so that it could form what she understood would be an "*assessment or a review of the concerns of neglect with respect to [Grace]*". She said that she logged each item of clothing and photographed them so that there would be a record maintained of what exactly was returned to Grace after the 20 years that she had spent with Mrs. X.
- 5.23 The Commission was provided with photographs of the contents of the boxes. The photographs showed a variety of clothes, such as t-shirts, tops, jumpers, pants, tracksuit pants, underwear, shoes, socks, and hair ties. Some stains or signs of shabbiness were visible on some, but not all, of the items that were photographed.
- 5.24 Other than the above clothing and hair accessories, there were no other belongings, documents or photographs in the boxes.

- 5.25 With regard to the matter of Grace's worldly belongings, as reported in Chapter 4 of the Commission's First Substantive Interim Report,¹² Mrs. X recalled during her evidence that, when Grace arrived at her house in February, 1989, she had only one shoe on and, apart from what she was wearing, had no other belongings, having come from a temporary host family rather than from her previous foster home with Family A. In this regard, Mrs. X said that Grace arrived with "*only her keys [and]...[w]hat she had on her.*" When asked about the matter during her evidence to the Commission, Mrs. X said that, back in 1989, Ms Greaney had said to her: "*all she has is one shoe and her keys*".
- 5.26 On the evidence, the Commission is satisfied that, sadly, when Grace came to Family X aged 10 years of age, she had no money, no clothing (apart from what she wore on the day), no photographs and no belongings, except for the plastic keys that she kept with her at all times.

Eating out and trips/drives

- 5.27 The Commission heard evidence from Mrs. X and also from Gamma and Alpha that Grace went shopping with Mrs. X and Mr. X to one of the nearby towns and that they would occasionally eat out in a Chinese or Indian restaurant there. The Commission is satisfied that Gamma would drive Mrs. X and Grace to town after Mr. X became ill and that Alpha, Mrs. X's grandson, or Q.Q., who also stayed with Family X, sometimes went with them.
- 5.28 In her evidence, Mrs. X also said that they took Grace to different places and referred to going to a nearby seaside town and going on drives. The Commission has taken into account Gamma's evidence that he drove Mrs. X and Grace around when Mr. X could no longer drive and that there were occasional drives to other places over the years. The Commission did not have evidence of any particular expenditure on Grace on these trips; however, it is reasonable to infer that some minor expenses may have arisen, such as fuel and refreshments.

Grace's hair care

- 5.29 A specific issue with respect to expenditure from Grace's Disability Allowance arose during the PCP meeting on Friday, 3rd July, 2009 (referred to above) in the following

¹² See paragraph 9.46 of Chapter 4 of the First Substantive Interim Report (page 156).

context. One of the topics for discussion at the meeting, which was attended by Mrs. X, Ms D, Ms B, Ms Burke, and CW6, was a proposal that Grace be taken by staff of Day Service Provider A on a day out that was being organised for the female service users who attended the centre. The day was to consist of a trip to a hairdresser and beauty therapist together with a shopping trip. Mrs. X was told at the PCP meeting that the cost of the day out, which was to include a haircut for Grace, would be approximately €200 to €300.

- 5.30 Grace always had long hair. Sometimes it was in plaits and sometimes it was tied up. A note of the PCP meeting was made by Ms B, in which she recorded that Mrs. X *“was unsure about [Grace’s] getting her hair cut but that a wash and dry might be better as [Mrs. X] did not like to cut her hair”*. Ms B recorded that Ms D asked if there was any reason for this and that Mrs. X had said that Mr. Smith had advised her that Grace’s mother preferred her hair long.
- 5.31 This note was subsequently emailed by Ms B to Mr. Smith, copied to Ms Browne. In her email, Ms B recorded that Mrs. X *“stated that she was told when [Grace] was first put in her care that [Grace’s] mother never wanted her hair to be cut. She said this was reiterated by [Mr.] Smith when he visited [Mrs. X] and [Grace] initially. According to [Mrs. X], [Mr. Smith] stated that [Grace’s] mother would be glad to know that [Grace’s] hair had never been cut.”* Ms B recorded that Mrs. X *“stated that she did not feel that there was anything wrong with [Grace’s] hair.”*
- 5.32 Mrs. X said in her evidence to the Commission that it was Ms Greaney, Children’s Officer of the SEHB, who had told her not to cut Grace’s hair. Whether or not this evidence is correct could not be tested. Ms Greaney was deceased before the Commission’s establishment. However, since Grace’s mother had not seen her since infancy and Ms Greaney had not been involved in Grace’s case since the 1990s, the Commission is not satisfied that this was why Mrs. X resisted a trip to the hairdresser for Grace.¹³
- 5.33 At the meeting, Mrs. X said that she had only trimmed Grace’s hair over the years and that, perhaps on this day out, the hairdresser would trim Grace’s hair. The note then recorded that it was agreed by all that the hairdresser would trim Grace’s long hair.

¹³ Ms Greaney retired from her role as Children’s Officer in the SEHB in 1998. Prior to that, she had handed over responsibility for Grace’s case to a SEHB social worker in 1994.

- 5.34 Notwithstanding Mrs. X's apparent agreement to having Grace's hair trimmed, a few days later, on 6th July, 2009, Ms D telephoned Ms B and informed her that Grace's hair had been cut over the weekend. Ms B emailed Ms Browne about the matter on 15th July, 2009, copying Mr. Smith, who was on leave. In her email, she provided a detailed update regarding the PCP meeting and about Grace's hair having been cut, stating that "[i]t was longer in places and appeared to have had [circa] 2 inches cut off the end of her 'pony tail'." Ms B also stated in her email that Mrs. X had informed Grace's key worker in Day Service Provider A that she had cut Grace's hair because she had not wanted Day Service Provider A to do it and because she did not want her hair to be cut again.
- 5.35 Ms D remembered Grace's arriving at Day Service Provider A with her hair cut that Monday. Ms D said that it appeared to her that somebody had taken hold of Grace's ponytail and "*chopped*" it. She said in evidence that Grace's hair "*didn't look acceptable*" and that, in her view, Mrs. X's actions showed a complete lack of regard for Grace's dignity. She said that it was "*very undignified that somebody would do that to an adult*" and she thought that that was probably why the matter had been reported to the HSE.
- 5.36 Ms B's evidence was that they were concerned by this, not only because of the uneven way in which Grace's hair was cut (which she described as "*dreadful*") but also because it had been cut after it had been suggested that a significant part of Grace's Disability Allowance might be used to pay for a haircut as part of the pampering day. In Ms B's opinion, it was an "*indicator of financial abuse*" and added to Day Service Provider A's existing concern in relation to Grace's finances. Ms B said that she felt that Grace's hair was cut because Mrs. X did not want to provide a portion of Grace's Disability Allowance to go to the hairdresser.
- 5.37 CW6, who was Grace's key worker at that time, spoke with Mrs. X who told her that she had cut Grace's hair because she did not want Day Service Provider A to do it. When she was asked about this incident at the Commission, Mrs. X said that she could not ever remember cutting Grace's hair and could not remember this occasion. However she did not deny that it had occurred.
- 5.38 Mrs. X gave evidence that Grace's hair was trimmed from time to time, saying "*it was cut, it was trimmed.*" She said that Grace was brought to a "*private*" hairdresser who worked from home, in a nearby town, not on a regular basis but "*whenever the*

hairdresser said to take a tiny bit off". Her evidence was however vague on the topic. She thought this happened "*maybe twice a year*". Mrs. X said that she started to take Grace to the hairdresser "*a couple of years*" after she was placed with Family X. She said that the hairdresser, whom she named, had since died. Whether or not Grace's hair was ever trimmed by anyone other than Mrs. X (a matter that cannot be established) the Commission is not satisfied on the evidence that this was ever the norm.

5.39 In a Garda statement dated 27th October, 2012, CW2 had said that "[Mrs. X] *didn't want [Grace's] hair cut. I used to feel sorry for her in the summer, [Grace] would be scratching at her head. Her hair was so thick and long, I am sure her head was hot and itchy.*" Mrs. X had no comment to make in respect of this statement from CW2.

5.40 In a Garda statement dated 13th June, 2011, CW8 had stated: "*I know someone [in Day Service Provider A] contacted [Mrs. X] to see if we could bring [Grace] to get her hair cut because it was gone so long, but we weren't let and we were told she would get it done herself.*" Commenting on this statement, Mrs. X said "*I got [Grace's] hair trimmed*" but she did not remember the staff of the day centre asking her for permission or telling them that she would arrange it herself.

Findings

5.41 The Commission is satisfied that avoiding the cost of Grace's being taken to the hairdresser was the main reason why Mrs. X cut Grace's hair on this occasion in July, 2009. It was clear that Mrs. X did not regard a visit to the hairdresser as a justified expense on Grace's behalf and if she had ever attended a hairdresser in the past, the Commission is not satisfied that this was ever part of Grace's normal routine.

5.42 Therefore, there was no reliable evidence that any expenditure from Grace's Disability Allowance was accounted for by money spent on personal grooming throughout the years that Grace lived with Family X.

6. Discussions between Mrs. X and Ms B following Grace's move

6.1 On 23rd July, 2009, six days after Grace was removed from Mrs. X's care, Ms. B and Mrs. X spoke on the telephone. Ms B made a note of the conversation (reported

immediately below) and had some recollection of the conversation when she gave evidence to the Commission. Mrs. X did not recall this conversation. While she agreed with the substance of their discussion on finances, she disputed that these were matters discussed with Ms B at this time. The Commission is satisfied, however, that the matters below did form part of their conversation.

- 6.2 Specifically, in relation to finances, Ms B noted that Mrs. X said that she was given no money for caring for Grace, that her money had been “*stopped*” in 1998 and that she had to write to get “*Carer’s [Allowance]*.” On the evidence to the Commission, there was a period of almost 14 months while Grace was placed with Family X during which Mrs. X was not paid a Carer’s Allowance with respect to Grace and when the Children’s Allowance had ceased. Mrs. X recalled speaking to Mr. Smith about that but she did not remember mentioning it to Ms B.
- 6.3 Ms B’s note stated that Mrs. X said “*we put our money together, me & [Grace]*” and, during her evidence, Mrs. X said this was a true reflection of the position. Ms. B also noted that Mrs. X said that they “*lived it up*” and “*had a good time*” and that “*what’s mine was hers and what’s hers was mine*”, which Mrs. X said was also correct.
- 6.4 Ms B noted that Mrs. X stated (when asked) that she had clothes belonging to Grace but added “*I know those kind of homes, they have loads of clothes there for the children*”. Ms B recorded that she told Mrs. X that new clothes would be purchased for Grace, since she did not have any of her own, to which Mrs. X responded that “*those material things*” meant “*nothing*” to Grace and that Grace had been happy living with her. Ms B recorded Mrs. X as then saying “*I loved her, I always will.*”¹⁴
- 6.5 In a further conversation with Mrs. X on 24th July, 2009, Ms. B noted that Mrs. X expressed concern about her financial position and that she advised Mrs. X to contact “*Citizens Information*” and the Department of Social Welfare regarding her pension entitlements. In her evidence, Ms B recalled that the conversation in relation to Mrs. X’s financial position went on for some time. She said that Mrs. X was concerned about her finances, given that she would no longer be in receipt of a Carer’s Allowance for looking after Grace. Mrs. X would also not have been collecting Disability Allowance on behalf of Grace once Grace was moved. Mrs. X had no recollection of this conversation.

¹⁴ See Chapter 6 of this Volume.

- 6.6 Mrs. X's concern with respect to the loss of a Carer's Allowance, in circumstances where she had substantially relied upon this income over the years, was an understandable concern for her to have expressed to Ms B at this time. Evidence with respect to Grace's case from March, 2001, reported in the Commission's Second Substantive Interim Report and referred to below, reflected the fact that Mrs. X, to the knowledge of the SEHB, relied on both the Carer's Allowance and Grace's Disability Allowance in the running of the household.
- 6.7 As reported upon in Chapter 10 of the Second Substantive Interim Report, in mid-February, 2001, a professionals' meeting was convened in respect of Grace's case, when it was thought that a phased plan would be put in place for her to be moved into residential care. Ms Catherine Hogan, Ms Sandra Merity, Mr. M, Ms Kathleen O'Sullivan and Ms Dianne Leyshon were in attendance. The official typed minutes were prepared by Ms Leyshon on 23rd February, 2001 and recorded the following recommendations:

"Recommendations of the Meeting:

- 1. A phased plan be put in place to enable [Family X] to gradually relinquish the full time care of [Grace].*
- 2. To encourage opportunities for [Grace] to socialise and integrate with her own peer group.*
- 3. Encourage [Family X] to allow [Grace] to avail of respite care i.e. 1 night away in [respite provider], a week's holiday in the summer arranged by [Day Service Provider A].*
- 4. Introduction to other parents through the [local voluntary association] e.g. [three named persons] to support [Family X] through separation. Explain the process of moving and how this will affect Benefits/Allowance. Disability Allowance would only be fully relinquished when [Grace] goes into full time residential care.*
- 5. Work towards relocating [Grace] to [Residential Facility A's] day care.*

6. [Residential Facility A] *Monday - Friday. Home weekends. Foster parents would receive a proportion of D.A. [Disability Allowance]*

7. *Home Support Worker to be discussed with Mrs [X]."*

8. *Reviews to be held to monitor the progress. If no movement by January, 2002 Health Board to consider legal action e.g. wardship"*
(emphasis added).

- 6.8 As reported in the Commission's First Substantive Interim Report, in a subsequent letter dated 8th March, 2001 from Ms Leyshon to Ms Marie Beville, Acting Senior Social Worker, SEHB, Ms Leyshon noted the financial contribution that Grace brought to Family X in terms of Disability Allowance and Carer's Allowance and stated that Mrs. X was dependent on this income.
- 6.9 Similarly, Ms Leyshon's note of a later Professional Workers' meeting held on 21st March, 2001 "*to consider the long term care plan for [Grace]*" recorded, among other things, that Ms Leyshon mentioned at the meeting the reliance placed by Family X on the income that Grace brought to the household "*in terms of the Carer's Allowance and Disability Allowance*". Regarding a proposal that Grace would move to residential care Monday to Friday and that Mrs. X would take Grace on weekends, Ms Leyshon noted: "*[Mrs. X] could still claim Carer's Allowance and Disability Allowance on a pro-rata basis*". Ms Leyshon also recorded that Ms Merity suggested that Mrs. X could be invited to apply for other positions of care work, such as Home Support Worker, in order to supplement her income.
- 6.10 The Commission is satisfied that no issue arose among the core professionals within the health board involved in Grace's case with regard to how Mrs. X was applying any of Grace's Disability Allowance at this time.

The question of an accumulated balance

- 6.11 The issue of whether Mrs. X had retained any accumulated balance from Grace's Disability Allowance over the years arose in correspondence from Ms B to Mrs. X in March, 2010. Mrs. X had not been asked for that, nor had she proffered any such sum for Grace prior to that date.

- 6.12 On 5th March, 2010, Ms B wrote to Mrs. X informing her that Grace had been made a Ward of Court. Her letter referred to a discussion she had with Mrs. X in July, 2009, wherein Mrs. X had stated that she had kept aside some of Grace's income as savings for her. Ms B asked Mrs. X to forward details of the funds, stating that they needed to be lodged with the President of the High Court.
- 6.13 On 25th March, 2010, Mrs. X replied to Ms B. She wrote that she had indicated to Mr. Smith and Ms Griffin in 2009 that Grace had no savings, that they had put their money together, and that they lived that way. Mrs. X also wrote that she would send money the following month, *i.e.* in April, 2010. In early April, 2010 Mrs. X wrote to Ms B, enclosing a cheque dated 9th April, 2010 in the sum of €1,200.00. In her letter, she expressed the hope that Grace was well and happy. She said that she missed Grace, but that she had known that one day Grace would leave her.
- 6.14 In relation to this sum, Mrs. X initially told the Commission that “... *between us all I got € 1,300...and I gave it to [Ms B]*”. Later, she told the Commission, that “*I put her money and my money together and when she left I only had € 1,300 to give her and I sent it to [Ms B]*.” When she was asked what was meant by this, she said that this sum was “*of savings left*” (while Mrs. X referred to the sum as €1,300 in her evidence, this was inaccurate as the sum sent was €1,200).
- 6.15 Mrs. X referred to Mr. Smith's visit to her in September, 2007, saying “[Mr.] *Smith came to visit and he said: ‘You know you should be putting money away for [Grace]’ ...I said ‘whatever money I have I will give it to you’, and he said: ‘Just start saving now’, and within about three weeks or four I sent the money to [Ms B]*.” She said that she put money away for Grace and got up to €1,300 and gave it to Ms B.
- 6.16 When she was asked if it was all of Grace's money that she was putting aside or a portion of it, Mrs. X said that it was “*a portion of the money*” that she was receiving for Grace. However, when she was queried further on how she put the money together, she said that she had gone to the bank and that her brother had helped her to get the money.
- 6.17 The sequence above put forward by Mrs. X was clearly inaccurate as Mrs. X sent €1,200 to Ms B in April, 2010, and then only after Ms B had requested it in March, 2010.

- 6.18 The Commission is satisfied that the sum sent to Ms B for Grace in April, 2010 was a sum put together by Mrs. X on foot of Ms B's request, rather than a sum set aside as the unexpended portion of Grace's Disability Allowance. The Commission finds that it could not be regarded as the calculation of the accumulated balance from Grace's Disability Allowance, but was a figure that was somewhat arbitrarily calculated as representing what was due to Grace or simply the sum that Mrs. X was able to produce.
- 6.19 Mrs. X's evidence was that Ms Greaney told her to put her and Grace's money together, saying "*she told me whatever money would come, it would be between us...*" Whether or not Ms Greaney had said this to Mrs. X, Ms Greaney's involvement in Grace's case (reported in the First Substantive Interim Report) was limited to the period when Grace was a foster child in Mrs. X's care. The Commission is not satisfied that Ms Greaney's involvement was relevant to the issue of the management of Grace's Disability Allowance, to which Grace became entitled to in her own right as an adult, Ms Greaney having handed over responsibility for Grace's case to a social worker in 1994, and retired in 1998.

7. Application of Grace's Disability Allowance – post July, 2009

- 7.1 The evidence with respect to the manner in which Grace's Disability Allowance was applied over the years after she was moved into the residential placement with the local voluntary association in July, 2009 up until the end of 2012, was informative for the Commission. It provided a useful illustration of the way Grace's Disability Allowance was spent on her behalf in her residential placement at this time. The expenditure from Grace's Disability Allowance over the above period is reported here only as a reflection of the types of expenses to which a person's Disability Allowance might be applied for that person's benefit.
- 7.2 The Commission was provided with Grace's bank statements and receipts during the period from mid-July, 2009 to the end of 2012. From these statements and from the evidence of Ms D, it was established that Grace's Disability Allowance was applied to discharge three main outgoings as follows:
- Grace paid rent (which was later subsidised) to the local voluntary association;

- Grace paid a contribution to the local voluntary association for utilities and groceries each week; and
- Grace paid Day Service Provider A money each week for transport fees and a contribution towards dinners.

7.3 Grace had other daily expenses, such as activities, takeaway food, clothes, paracetamol, and certain prescriptions which were discharged from her Disability Allowance. In this regard, Ms D confirmed to the Commission that Grace effectively had to pay for everything herself from her allowance.

7.4 Grace's Disability Allowance was €204.30 *per week* in 2009 when she was moved into residential care. It was reduced to €196.00 in January, 2010 and reduced further in January, 2011 to €188.00 *per week*.

7.5 When Grace's bank account was opened in September, 2009, she was entitled to back pay in respect of her Disability Allowance in the sum of €1,430.10, which accounted for seven weeks' Disability Allowance at €204.30 *per week*.

7.6 The payment of €1,200.00 received from Mrs. X (referred to above) was lodged to Grace's bank account in June, 2010.

7.7 The balance in Grace's account in October, 2012, after monies were applied from her Disability Allowance on her behalf, was €353.55.

7.8 In the course of his evidence to the Commission Mr. Pat Walsh, Acting General Manager, HSE Waterford Community Care, observed that *"in circumstances where people are in receipt of Disability Allowance or that, there are legitimate charges. If somebody, for arguments sake, is in [the local voluntary association] today or any other of the organisations, they are probably charged 80 per cent of their disability allowance as a legitimate charge. If they go for an outing or personal grooming or whatever, that they pay that out of their balance as well."* Mr. Walsh said that he thought that this was now regulated, *"...whereas back at this time it may not have been, I'm not quite sure of that, that 80 per cent."*

7.9 The above expenditure is reported as an illustration only of the type of expenses to which the Disability Allowance could be and was applied for Grace's benefit in the

period after she left Mrs. X's care. The extent of the evidence with respect to Mrs. X's expenditure from the Disability Allowance is considered separately above.

- 7.10 Considering the evidence with respect to the spending of Grace's Disability Allowance by Mrs. X and the above balance in the period after Grace's move to residential care, the Commission is satisfied that the following facts are established.

8. Findings

- 8.1 With regard to the definition of "abuse" provided in the Commission's Terms of Reference, there were no allegations to the Commission of Grace's having been subjected to *"financial transactions to which the person does not or cannot validly consent, or which are deliberately exploitative"*. Further, there was no evidence of any such transactions in the course of the Commission's investigations. The focus of the Commission's investigations therefore was on how the weekly sum by way of Grace's Disability Allowance was applied by Mrs. X and whether this was spent for Grace's benefit.
- 8.2 Having regard to the figures provided to the Commission, reported above, the total of the DPMA/Disability Allowance payments which Grace was entitled to between September, 1996 to July, 2009, a period of almost 13 years, was in the sum of €88,753.46.
- 8.3 Grace was entitled to her Disability Allowance in her own right. However, Mrs. X, as her agent, was entitled to and had a responsibility to use the payment for Grace, with the balance, if any, to be held for the benefit of Grace. The nature of the payments that might be made for the benefit of the person entitled to the Disability Allowance was not prescribed or defined further in the Guidelines submitted by the Department to the Commission.
- 8.4 As reported above, Ms Conroy gave evidence of how an eligible person who had an illness or a medical condition that was expected to last for at least a year and who was substantially restricted in obtaining employment could receive Disability

Allowance. The Commission accepts that Grace's Disability Allowance was, therefore, intended as a substitute for her being able to earn a living to enable her to pay for the usual costs of living, such as food and housing costs.

- 8.5 While Grace lived with Family X, Mrs. X did not formally deduct or purport to deduct any part of her Disability Allowance as representing a sum in lieu of rent, or for utilities or groceries, even though such costs were incurred in providing accommodation and meals for Grace.
- 8.6 As reported above, once Grace was moved into the residential placement with the local voluntary association, a large proportion of her Disability Allowance was applied to discharge her rent, utilities and groceries.
- 8.7 The Commission finds that Mrs. X did not hold Grace's Disability Allowance separately, but pooled it in a common fund together with her own Carer's Allowance. All aspects of Grace's keep were financed from the pooled income within the Family X household. Mrs. X did not differentiate between the source of general household expenditure and expenditure from the contribution of Grace's allowance that could be identified as being for Grace's sole benefit or from which she partially benefited. No household accounts or records were maintained documenting how monies from Grace's Disability Allowance were applied or recording the unspent cumulative balance, if any, that was left over. Clearly, to have expected Mrs. X to have maintained records of all household expenditure would be to ignore the realities of ordinary daily life. However, the fact that no such records were maintained meant that the evidence did not exist to permit the Commission accurately to establish the proportion of Grace's Disability Allowance expended by Mrs. X on her behalf on a weekly or cumulative basis.
- 8.8 The Commission is satisfied, however, that Grace's Disability Allowance was drawn on by Mrs. X for Grace's keep with Family X and that a portion of the allowance from the pooled monies was, in all likelihood, spent on food and other household utilities and expenses from which Grace also benefited. A portion was also applied to Grace's attendance at Day Service Provider A (€30 per week when Grace attended) and there were expenses that arose from time to time, associated with eating out and going out.

- 8.9 As reported upon in Section 5 above, it was clear from the evidence to the Commission that, by virtue of her profound disabilities, Grace could not and did not express any preference or desire for material possessions to be purchased for her, or to go to particular places, engage in particular activities or to spend money on herself. Grace's world was generally either at home with Mrs. X or at her day placement. The Commission accepts that, from the evidence from her placement and from Day Service Provider A, Grace's interest in material items was mostly confined to her plastic keys which she kept with her at all times.
- 8.10 With respect to her personal items, the Commission is not satisfied on the evidence that Mrs. X applied a significant portion of Grace's Disability Allowance towards her clothing. As reported above, the Commission does not accept Mrs. X's evidence that she always bought new clothes for Grace. The evidence tended to point to Grace's clothes as well-worn and of an older variety. The Commission considers it likely on the evidence that the sum expended by Mrs. X on Grace's clothing was always at a very modest level. In addition, the Commission found no evidence of expenditure on Grace's personal care or her grooming, apart from on items such as toiletries.
- 8.11 In considering the evidence with regard to the use of Grace's Disability Allowance, the Commission took into account that, in all likelihood, there was unidentified miscellaneous expenditure for Grace over a period of approximately 13 years over which Grace was entitled to Disability Allowance.
- 8.12 The Commission thus considered any suggestion that Grace was wrongfully deprived of the benefit of the total amount of her DPMA/Disability Allowance payments, totalling €88,753.46, over the almost 13 years under consideration, to be without evidential foundation. The annual totals of the Allowance paid are detailed at paragraph 3.19 above. The euro figures provided to the Commission ranged from 4,364.18 total for 1997/1998 to 10,483.40 total for 2008/2009. Taking an average of payments over the years into consideration, the Disability Allowance amounted to approximately €7,000 *per annum* by way of a living allowance for Grace. The Commission is satisfied that the allowance, which was provided to Grace through Mrs. X as her agent, was money that was to be used as a basic living allowance for Grace (always provided that it was applied for her benefit).
- 8.13 Taking into consideration Grace's complete reliance upon Family X for all aspects of her daily care and her keep and having regard to her position as a member of the

Family X household, the Commission accepts that, in all likelihood, cumulatively, the amount of Grace's Disability Allowance that was attributable to expenditure for her benefit by Mrs. X, was not an insubstantial part of that allowance.

- 8.14 In the absence of records detailing how Grace's weekly Disability Allowance was applied, the Commission clearly cannot accurately establish what cumulative balance ought to have remained from that allowance after almost 13 years. However, even taking account of the basic level of the Disability Allowance, the Commission cannot be satisfied on the evidence that the figure of €1,200 sent by Mrs. X to Ms B after Grace was moved to a residential placement, as reported above, properly represented the cumulative balance of the weekly allowance that was not spent on Grace and her keep over the 13 years in question. The Commission considers that the figure should have been higher than € 1,200 and, in so concluding, it has had specific regard to its findings on the evidence with respect to Grace's presentation and her clothing, referred to above, indicating only a modest level of expenditure on such things; the clear evidence that Grace's monies were subsumed into the household budget; and the clear inference from this evidence that her monies were therefore sometimes applied to items or expenses not necessarily attributable to her particular requirements or that her monies were retained by Mrs. X for her (Mrs. X's) own use.
- 8.15 The Commission finds that some of Grace's Disability Allowance, money that could have been applied weekly for her care, was not spent on her. The most obvious examples of the lack of spending on Grace's care were the state of her clothing, which was old-fashioned and well-worn, and the poor standard of her presentation, particularly with regard to her hair. This evidenced a view that expenditure at a minimal level on these aspects of Grace's care was sufficient. The Commission is satisfied that there was a clear association between the manner in which Grace's Disability Allowance was applied by Mrs. X and these areas of neglect of aspects of Grace's presentation, which have been reported upon in Chapter 3 of this Volume.
- 8.16 The Commission is therefore satisfied on the totality of the evidence that there was a level of financial mismanagement or abuse by Mrs. X of Grace's Disability Allowance in breach of her duties as Agent, such that Grace did not receive its full benefit over the years that she resided with Family X. The precise amount of the allowance not applied to Grace's benefit cannot be established. Given the nature of the evidence, however, the Commission cannot be satisfied that the accumulated amount of the

allowance from which Grace did not benefit was likely to have been a very substantial portion of the allowance.

- 8.17 In reporting upon the manner in which Grace's Disability Allowance was managed by Mrs. X, it is also important to reiterate that there was no evidence to the Commission (prior to September, 2007 when Mr. Smith and Ms Griffin visited Mrs. X as reported above) that the issue of how Grace's Disability Allowance was spent by Mrs. X was ever raised with her by any official of the SEHB or the HSE. In this regard, Mrs. X simply managed Grace's care to the standard that she deemed fit and applied Grace's Disability Allowance accordingly without any oversight or direction. Having regard to the HSE/SEHB's duty to monitor Grace's care when she continued in the Family X placement into adulthood (in accordance with the decisions made by the SEHB/HSE in her case, as already reported in both the First and Second Substantive Interim Reports), the Commission is satisfied that this was another aspect of the failure of the SEHB/HSE to discharge their duties to Grace with regard to the monitoring of her placement on an ongoing basis.

END

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CHAPTER 6

1. Introduction

- 1.1 The focus of this Chapter is on whether the evidence established that Grace was subjected to abuse, specifically in the form of emotional abuse. The Commission has examined the evidence directly related to this issue in order to establish if Grace was subjected to abuse of this kind during the time she spent with Family X from early 1989 until July, 2009.
- 1.2 The question of whether Grace was subject to other types of abuse has been addressed in separate chapters. This Chapter reports on the question of emotional abuse as a “stand-alone” issue to be considered rather than as a potential outcome of any other categories of abuse or neglect considered in the other chapters of this Volume. This is in order to capture and consider evidence that might relate to this issue alone, rather than being an adjunct of any of the other aspects of potential abuse which the Commission has examined.

2. Emotional abuse

“Abuse” per the Terms of Reference

- 2.1 The meaning of the term “abuse” provided in the Commission’s Terms of Reference, is repeated for ease of reference. It means:

“any act, or failure to act, which results in a breach of a vulnerable person’s human rights, civil liberties, physical and mental integrity, dignity or general well-being, whether intended or through negligence, including sexual relationships or financial transactions to which the person does not or cannot validly consent, or which are deliberately exploitative. Abuse may take a variety of forms.”

- 2.2 The above definition did not explicitly refer to the issue of emotional abuse; however, the Commission has considered acts, or failure to act, resulting in a breach of a vulnerable person’s mental integrity, dignity or general well-being, as sufficiently wide to enable a consideration to be undertaken as to whether or not evidence provided

with respect to Grace's care and treatment when she lived with Family X was such as to establish that she had been subjected to emotional abuse over that time.

Emotional abuse – range of definitions

- 2.3 As with all aspects of potential abuse investigated by the Commission, the question as to whether it was established as a matter of fact that there had been emotional abuse, was grounded in an examination of broad evidence concerning Grace's life over the period under investigation. Given the potentially intangible nature of emotional abuse in any given case, the Commission notes the following.
- 2.4 Expositions by way of examples only of the term "*emotional abuse*" are contained in a number of publications/guidelines published by the Department of Health, the Department of Children and Youth Affairs, and the HSE/Tusla concerning vulnerable adults and children, some of which post-date the time period under investigation by the Commission.
- 2.5 They are set out below as illustrative only of circumstances and behaviours that may evidence emotional abuse or ill-treatment of a child or vulnerable adult in a particular case. These descriptions are very broad in nature, and accompanied by observations that emotional abuse is often difficult to evaluate or recognise in a given case. Defining and identifying emotional abuse is not a straightforward exercise, not least when considering the position of a person with profound intellectual disability with consequent maladaptive behaviour patterns and with difficulties in communication and understanding, as was the position with Grace.

Emotional abuse of children

- 2.6 In 1987 the Department of Health released its "*Guidelines on Procedures for the Identification, Investigation and Management of Child Abuse*" (the "Guidelines of 1987"). The Guidelines of 1987 stated that child abuse included emotional abuse, but they did not define such abuse.
- 2.7 In May, 1994, the South Eastern Health Board published a document entitled "*Procedures for the Investigation and Management of Cases of Suspected Child Abuse, 1994*" ("the 1994 Procedures"). The document had been agreed between various professional disciplines within the health board involved in child protection

and its stated focus of the document was *“the protection of children”*. A significant feature of the 1994 Procedures was that it defined emotional abuse of a child as *“inadequate nurturing of a child including verbal, emotional attacks or the denial of love; leading to significant physical, mental or emotional problems.”*¹

- 2.8 The document *“Children First: National Guidelines for the Protection and Welfare of Children”*, was first published by the Department of Health in 1999 and fully revised and updated by the Department of Children and Youth Affairs in 2017 (*“the 2017 Guidelines”*). According to the 2017 Guidelines, emotional abuse is *“the systematic emotional or psychological ill-treatment of a child as part of the overall relationship between a caregiver and a child. Once-off and occasional difficulties between a parent/carer and child are not considered emotional abuse. Abuse occurs when a child’s basic need for attention, affection, approval, consistency and security are not met, due to incapacity or indifference from their parent or caregiver. Emotional abuse can also occur when adults responsible for taking care of children are unaware of and unable (for a range of reasons) to meet their children’s emotional and developmental needs. Emotional abuse is not easy to recognise because the effects are not easily seen.”*²
- 2.9 The 2017 Guidelines observe that: *“A reasonable concern for the child’s welfare would exist when the behaviour becomes typical of the relationship between the child and the parent or carer.”*
- 2.10 Additionally, the 2017 Guidelines set out a broad range of actions that may be considered evidence of emotional abuse in a given case, ranging from bullying, rejection, persistent criticism, sarcasm, hostility or blaming, lack of comfort and love or attachment or proper stimulation, lack of continuity of care (e.g. frequent moves, particularly unplanned), extreme overprotectiveness, conditional parenting, inappropriate non-physical punishment (e.g. locking a child in a room), ongoing family violence/conflict, or seriously inappropriate expectations of a child relative to his/her age and state of development.

¹ Both the Child Abuse Guidelines of 1987 and the 1994 Procedures are examined in more detail in Section 4 of the Commission’s First Substantive Interim Report.

² The 1999 Guidelines stated that: *“Emotional abuse is normally to be found in the relationship between a caregiver and a child rather than in a specific event or pattern of events. It occurs when a child’s needs for affection, approval, consistency and security are not met. It is rarely manifested in terms of physical symptoms.”* They listed a number of examples of such abuse, before going on to state that *“[c]hildren show signs of emotional abuse by their behaviour (for example excessive clinginess to or avoidance of the parent/carer), their emotional state (low self-esteem, unhappiness) or their development (non-organic failure to thrive). The threshold of significant harm is reached when abusive interactions become typical of the relationship between the child and parent/ carer.”*

- 2.11 The 2017 Guidelines include the observation that no one indicator is conclusive evidence of emotional abuse and that emotional abuse is more likely to impact negatively on a child where it is persistent over time and where there is a lack of other protective factors.

Emotional abuse of vulnerable adults

- 2.12 With regard to vulnerable adults, in 1997, the South Eastern Health Board prepared a draft policy and procedures document on the protection of vulnerable adults from abuse, which said as follows in respect of emotional abuse:

“Many vulnerable adults can be susceptible to emotional abuse. Each individual has the right to live in a caring environment where care should be given unconditionally and without resentment. The person should have a sense of acceptance and approval by others and should not be subjected to an unreasonable level of criticism. The person should feel a sense of security within the home environment. It is an extremely difficult task to evaluate this form of abuse even for experienced clinicians.”

- 2.13 In 2005, the Health Service Executive for the South East area prepared a policy and procedure document for the protection of vulnerable adults. Psychological and emotional abuse was defined in that document as:

“Controlling through fear by shouting, shaming or humiliating deliberately misinterpreting a person’s communication. This is the threat of violence or isolation, including name-calling or other forms of assault. It includes denial of basic rights, inclusive of choice, opinion or privacy, malicious teasing, taunting, unjustifiably ignoring or rejecting.”³

³ A further description of “emotional abuse” contained in the 2005 draft policy and procedure document is a restatement of that contained in the 1997 policy and procedures, set out at paragraph 2.12 above.

Preliminary

- 2.14 The issue for the Commission was whether or not the evidence established that Grace had been intentionally or negligently subjected to emotional abuse over the years that she lived with Family X.
- 2.15 Having regard to the extent and nature of the evidence that the Commission received with regard to Grace and to her profound level of intellectual disabilities, which included limitations in communication and in her capacity to understand as well as certain maladaptive behaviours exhibited by her, it was not possible to establish the facts with respect to whether she was subjected to emotional abuse by reference to a retrospective attempt to establish this from interpretation of her demeanour or mood or behaviours at any given time over the 20 year period under investigation. The Commission is satisfied that it would have been unsafe to have attempted to do so. Clearly, emotional abuse of Grace could not be automatically inferred by reference to her demeanour, her mood, or her behaviours on any particular occasion or occasions.
- 2.16 In brief summary, and taking account of the totality of the evidence heard by the Commission about Grace over the years that she resided with Family X from February, 1989 to July, 2009 and her attendance at Day Service Provider A, she was described as presenting at various times as happy, sad, excited, hyperactive, frustrated, anxious, noisy, aggressive, self-harming, quiet, smiling, laughing or withdrawn. Sometimes Grace was considered to be in good form, and sometimes she was not.
- 2.17 In considering whether or not there was evidence of conduct towards Grace in her placement with Family X in connection with the question of whether she had been subjected to emotional abuse there, the Commission focused upon the areas in the evidence that concerned Grace's daily life, referred to in Section 5 below. In accordance with the Commission's Terms of Reference in Phase One, the evidence considered in this Chapter is the evidence of and concerning Grace's care.
- 2.18 The evidence to the Commission, although extensive, could not be expected to present a complete and comprehensive picture of all aspects of Grace's daily life over a period of 20 years, and did not do so. Whereas some evidence considered by the Commission related to snapshots in time, other evidence reflected a longer term

or more sustained view of Grace's life. Nevertheless, the Commission is satisfied that it had valuable evidence upon which to consider the issue as to whether or not it was established that Grace had been treated in a manner that was emotionally abusive of her.

- 2.19 In considering particular areas of evidence in this Chapter, it should be noted that evidence with respect to many other aspects of Grace's care has already been considered and reported upon in the other chapters of this Volume.
- 2.20 The evidence with respect to the impact on Grace's mental health and the level of emotional disturbance that she suffered after she was removed from Mrs. X's care and placed in residential care in July, 2009, is considered and reported in Chapter 4 of this Volume and examined in the context of considering the significance of her presentation and behaviours following this move. The circumstances in which it was decided to move Grace into a residential placement and issues concerning the management of her case by the HSE between August, 2007 and July, 2009 have been reported upon in Volume 1.

Focus of the evidence

- 2.21 The Commission has focused in this Chapter upon evidence with respect to Grace's care under the following broad headings:
- relationships - communication and interactions;
 - Grace's attachment to her plastic keys and the question of punishment; and
 - aspects of Grace's daily life – at home and in Day Service Provider A.
- 2.22 The Commission has reported in Chapter 3 of this Volume upon the lack of schooling for Grace and the extent of her absences from Day Service Provider A, where a place was provided for her from September, 1995, as the Commission considers that those matters are more appropriately reported there. These matters have also been addressed in the Commission's First and Second Substantive Interim Reports.

3. Relationships - communication and interactions

- 3.1 There were no specific allegations at the Commission of instances of Grace's having been subjected to emotional abuse in the manner of communication with her and in interactions with her over the years that she lived with Family X.
- 3.2 The evidence to the Commission established that communicating with Grace was challenging having regard to the nature of her intellectual difficulties and to her inability to speak or to understand much of what was said to her.
- 3.3 Grace's dependence on Mrs. X as her primary carer was well established in the evidence received by the Commission. The nature of Grace's attachment to Mrs. X, which related to her dependence on Mrs. X, was clear from the evidence to the Commission.⁴ In her evidence, Mrs. X said that she was able to communicate with Grace. She said, "*I can't explain it, but myself and [Grace] could get on, as I am talking to you... [Grace] knew everything that I was saying, everything I was doing...*" The Commission is satisfied that Mrs. X was the person who talked to and communicated with Grace the most. She was the person most aware of Grace's level of understanding and of her means of communication.
- 3.4 Mrs. X's position was that she always felt that Grace had sufficient company at home and that she was better off living with Family X rather than being placed in institutional residential care. Mrs. X felt that Grace did not want anybody and she reiterated this in her evidence to the Commission. Mrs. X said that Grace was a loner. This was a description of Grace also given by other people, as referred to below. Mrs. X sometimes spoke in protective terms of Grace in the course of her evidence. When she was asked if she ever saw anyone abuse Grace or mistreat her sexually, physically or emotionally or by reason of neglect, Mrs. X replied: "*No one would touch [Grace]*".
- 3.5 It was clear from the evidence provided to the Commission that communication with Grace had to be direct and simple. This was borne out in early psychological assessments of her carried out in the years prior to her placement with Family X. The Commission's First Substantive Interim Report contains substantial information with

⁴ Evidence regarding the relationship between Mrs. X and Grace is reported upon, both in this Chapter, and at various points in Chapter 3 of this Volume.

respect to Grace's difficulties, her presentation, and her maladaptive behaviours and it should be read with this Chapter and Volume.

- 3.6 Assessment by a consultant paediatrician in January, 1985, noted that Grace *"will obey a firm command [though]...that can be extremely difficult."*
- 3.7 Assessment by a psychologist in February, 1985 reported Grace's presentation and communication in the following manner:

"[Grace] was seen twice and on both occasions her concentration deteriorated sharply after about ten minutes. She screamed frequently in a piercing fashion and would sometimes quit on request, others not. No differentiated sounds were heard. She sometimes responds to simple commands but frequently ignores these. She knows some of the parts of her body and will sometimes brush her hair etc. on command. She is hyperactive and runs and climbs much of the time."

- 3.8 A report of an assessment by a consultant psychiatrist in March, 1985 included the observations that Grace had a preoccupation with *"noise making"*, had no useful speech, and that she *"comprehends a few simple commands"*. This was also noted in the later report dated 27th January, 1989 by the Sister-in-Charge of the school Grace attended in the Eastern Health Board ("EHB area").⁵
- 3.9 Contemporaneous with Grace's placement with Family X in 1989, a psychological report was prepared in respect of her, which was compiled from assessments during January and February, 1989.⁶ At that stage Grace's profile of maladaptive behaviour on the Adaptive Behaviour Scale indicated that she was *"more hyperactive than 95% of [her] peers and [that] inappropriate interpersonal manners [were] worse than 92% of [her] peers."* The report noted that: *"She hugs others inappropriately does not let go, and also head butts. Staff feel [Grace] prefers to be alone. She occasionally bangs her head against the floor"*. In this regard, the report recommended: *"Do not let her hug inappropriately. Her arms should be removed and she should be told 'NO' when she squeezes too hard"*.

⁵ Reported upon in Chapter 4, Section 9 of the First Substantive Interim Report.

⁶ This is set out in full in Chapter 4, Section 9 of the First Substantive Interim Report, at paragraph 9.62.

- 3.10 An assessment of Grace made by Mr. Enda Mc Govern, Consultant Psychologist, Brothers of Charity, which was conducted in August, 1989, provided some detail of her capacities at that time.⁷ Under the heading of “psychological findings,” Mr. McGovern reported that Grace functioned intellectually within the profound range of mental handicap, and had a mental age of 17 months. He provided some detail about her capacities and reported that apart from one word (“no”), her speech was largely confined to syllables, while her receptive language was at the level of understanding very basic commands. He noted that “[h]owever, it is difficult to know if [Grace] is attending to the content of speech or more to the tone of authority conveyed in instruction”. Mr. McGovern reported that Grace would make gestures to communicate her needs and would respond to simple and familiar requests. Mr. McGovern reported that Grace would bang materials together and showed some enjoyment at the sound she heard. This related to Grace’s sensory processing difficulties, as reported upon in Chapters 2 and 4 of this Volume.
- 3.11 A further report prepared in May, 1995, following assessment of Grace by a clinical psychologist is set out in full in Chapter 6 of the First Substantive Interim Report.⁸ With respect to Grace’s communication skills, it was reported that: *“Throughout her assessment [Grace] smiled but did not use speech. She nods her head in response to a question but does not discriminate between ‘yes’ and ‘no’. She is reported to use some syllables but [Family X] tend to anticipate her needs rather than [Grace] making her needs known. [Grace] will attend to a conversation between others if she hears her name being uttered. She understands simple, familiar requests e.g. give me, [put] them in the box, wipe your mouth etc. She did not identify any common objects presented to her during assessment.”*
- 3.12 In her evidence, Mrs. X said that Grace only obeyed commands. She said that, if she was telling Grace to go to the toilet, she had to do so in a commanding voice. Similar observations were made by Day Service Provider A personnel. This way of communicating with Grace by way of simple “commands” continued to be the most effective way of prompting her to do ordinary day-to-day actions and was used at home and in Day Service Provider A where Grace’s actions, such as toileting and dressing, required to be so prompted. In that regard, CW1, who commenced working with Day Service Provider A in 1997 as a care assistant and was later employed as a programme assistant and a programme supervisor, said that Grace was prompted by

⁷ Reported upon at Chapter 5, Section 9 of the First Substantive Interim Report, at paragraph 9.22 *et seq.*

⁸ See Section 2 of Chapter 6 of the Commission’s First Substantive Interim Report.

others. She did not always spontaneously communicate but she did learn Lámh signs with a lot of repetition. For instance, CW1 indicated that Grace definitely responded to commands such as “*go to the toilet*”. However, she did not consider that Grace was independent in terms of her communication and said that her self-care was always heavily prompted.

- 3.13 Grace also communicated by actions. For instance, her action of taking off her clothes in the bathroom in Day Service Provider A was seen as a cue that she wished to have a bath. Such actions were part of Grace’s non-verbal or gestural communication system referred to by Mr. McGovern in the course of his evidence to the Commission.
- 3.14 In the report on Grace prepared by Mr. M on 27th November, 2000, he described communication with her in the following terms: “*People anticipate [Grace’s] needs rather than [Grace’s] making her needs known. She understands simple, familiar requests, e.g. go to the toilet, wipe your mouth, sit down, go to bed, it’s time to get up and your dinner is ready*”.⁹
- 3.15 In her evidence, Mrs. X maintained that when Grace was at home she (Grace) was very happy and she said that she was able to manage Grace in every way. This evidence conflicted somewhat with Mrs. X’s other evidence, where she said that Grace banged her head all the time at home and where she gave an account of having to leave shops with Grace because of Grace’s behaviours (the evidence with respect to Grace’s head-banging behaviour is reported in Chapters 2 and 3 of this Volume). However, Mrs. X told the Commission that she believed that Grace was “*so happy*” living with her, and she expressed this view throughout her evidence.
- 3.16 Mrs. X rarely highlighted any management difficulties with respect to Grace in the course of her evidence to the Commission. This was an approach that Mrs. X appeared to adopt with regularity in her engagement with SEHB or HSE personnel over the years and the Commission considers that, on the totality of the evidence, Mrs. X was unlikely to have wanted to draw attention to any such issues, given that she did not want Grace to be removed from her care at any stage. The issue of punishing Grace for being “*bold*” is reported below when considering the evidence with respect to Grace’s attachment to her toy keys.

⁹ Reported upon in Chapter 10 of the Second Substantive Interim Report.

Observations of Alpha

- 3.17 The Commission heard evidence from Alpha about Grace's time with Family X relevant to the matters under consideration in this Chapter. Alpha grew up with Grace and considered her to be his sister. He told the Commission that, when he was younger, he did not have an appreciation of her difficulties. He knew that she could not talk, and that was his understanding of it. In later years, as he grew up, he saw less of Grace; however, when he did see her, his evidence was that he thought that she always seemed happy and that she was always smiling. He said that she was still the same person she was when they were young.
- 3.18 With regard to Mrs. X's communication with Grace, Alpha said that she was able to talk to her and get through to her. When asked how Mrs. X would control Grace if she misbehaved when they were out, Alpha said that, as far as he could remember, there was no problem. He said, *"I suppose she [Mrs. X] could hold on to her at the elbow and just hold her so she didn't knock anything or, it is very rare I seen that happen"*. He said that it was never anything more than a hold. In relation to how Mrs. X would speak to Grace at these times, Alpha told the Commission that *"I suppose she would say "[Grace] stop' except it would be a little bit more abrupt."* His evidence was that it would be a firm tone and that this worked with Grace, adding that this tone *"worked with me anyway"*.
- 3.19 Alpha said that his memory was that Grace was not affectionate towards anybody other than Mrs. X. He said that he saw Mrs. X as being her *"number one"*. He told the Commission that if one did not know any different, one would swear the relationship between them both was that of a mother and daughter. Alpha viewed it in the same way as his relationship with Mrs. X. He also said that if something was wrong, or if he or Grace was upset, they would get a hug from Mrs. X.
- 3.20 From his perspective, Alpha described his home as a very happy place and having a loveable atmosphere. He said that it was like any normal household. Alpha said that he got on *"absolutely fantastic"* with Mr. X. His evidence was that both grandparents were the best in the world to him and that he could not have asked for better. Alpha said that the love and affection Grace got from Mrs. X, his grandmother, was second to none. He said that he never saw any sign of her being emotionally abused and he also strongly refuted any assertion that she had been abused in any other manner.

Observations of Gamma

- 3.21 Gamma also gave evidence of Mrs. X's manner of communication with Grace, saying that if Mrs. X told her to go and wash up, she would do it. He said that Grace reacted to her own name. Gamma said that if Grace became agitated in any way at a restaurant, Mrs. X would say "[Grace], *behave yourself*", and that Grace would respond to that. He also recalled that Grace could take a little fit of laughing for no reason.
- 3.22 In his evidence, Gamma said that Grace was "*happy in her own company*". His impression was that she seemed to like Mrs. X and recalled her holding Mrs. X's hand. He said that now and then Grace would go over and hold Mrs. X's hand but also that Mrs. X would call her and give her a hug. As Gamma saw it, Mrs. X treated Grace as her own daughter. Gamma said that he never saw Grace being mistreated in any way. He said that Grace was not denied anything or neglected in any way and stated, "[Mrs. X] *wouldn't deny anyone, the cat even, if I can put it that way to you.*"

Observations of Beta

- 3.23 In his evidence, Beta, who has lived on Family X's property since around the early 1980s, told the Commission that Mrs. X and Grace got on like "*a house on fire*." He said that Mrs. X looked after Grace "*a thousand to one*". He recalled that Grace went everywhere with Mrs. X and that they were close to one another. However, he said in his evidence that he did not see Grace often, as he was only there for a few minutes every time he went in.
- 3.24 Beta told the Commission that he and Mrs. X "*got on great*". He described Mrs. X as being "*like a mother to me. Like a mother to us all*". He described his relationship with Gamma as being "*like two brothers*", explaining that if he wanted to go somewhere, Gamma would bring him or that if Gamma wanted something, he would give him a hand. He also said that he and Alpha had a "*brilliant*" relationship. Beta was upset at the suggestion that anything negative could have occurred to Grace with Mrs. X. He told the Commission that he never saw Grace being mistreated or neglected in any manner whatsoever.

SEHB/HSE personnel

- 3.25 The Commission also considered the evidence of SEHB/HSE personnel drawn from observations as to the nature of Family X's interactions with Grace. Although this evidence consisted in the main of snapshots in time, it spanned the periods when Grace was both a foster child and a vulnerable adult, *i.e.* from 1989 to 2009.
- 3.26 It is a statement of the obvious that the observations of these interactions were not made when no outsiders were present; nonetheless, they were of evidential value in considering whether there was any indication or concern from these observations of emotional abuse of Grace over the years in which she resided with Family X.

The period from February, 1989 up to the year 2001

- 3.27 Occasions when Grace was observed in her placement with Family X by SEHB/HSE personnel over the above period have already been reported in both the First and Second Substantive Interim Reports. The observations referred to were those of Ms Kitty Greaney, the SEHB's Children's Officer; Ms Geraldine Kelly, a social worker in the SEHB; Ms Dianne Leyshon, a social worker in the SEHB; and Ms Helen Hawe, who was a public health nurse in the SEHB. These are referred to in summary form below.
- 3.28 Assessments of how Grace was getting on with Family X in the initial period of her placement were reflected in the views of Ms Greaney in March, 1989, who considered that Mrs. X was coping well with Grace.¹⁰ As reported upon in Chapter 5 of the First Substantive Interim Report, Mr. McGovern noted in August, 1989, at an early stage, six months after Grace's initial placement with Family X, that she "*seems to be getting on well with the family*" and "*appeared to be a child with a happy and sunny disposition, who is enjoying her current stay with [Family X], and they in turn have very positive things to say about [her] ...*"
- 3.29 Ms Greaney was the person within the SEHB who had by far the most contact with Mrs. and Mr. X from the date of her foster care placement with Mrs. X in February, 1989 up until 1995, when Grace began attending Day Service Provider A. Her role in Grace's case has been reported upon in detail in the First Substantive Interim Report. As reported, Ms Greaney was at all times positive in her view as to how

¹⁰ Reported upon in Chapter 4 of the First Substantive Interim Report.

Grace was being cared for by Family X. This was notwithstanding her belief that she should be placed in a residential institution.

- 3.30 Ms Kelly, who spent two hours in Grace's company at her foster home in July, 1995, had a very positive impression of how Grace was getting on. Grace appeared very well and happy and content. Nothing arose that gave Ms Kelly cause for concern in relation to Grace's care.¹¹
- 3.31 Ms Kelly described seeing Grace and Alpha in the garden during this visit. She told the Commission that she believed that they had a very close bond. Mrs. X's daughter had recently died in England and while Ms Kelly recalled Mrs. X as being very upset, she said that *"she was very appropriate and I thought she was very caring with [her grandson] and he was asking questions, you know, about his mother and she wanted to tell him honestly in the best way, but she was just looking for ways of going about it. It was just a very hard time for her."*¹²
- 3.32 The evidence of Ms Hawe, Public Health Nurse, also contained her impressions from 1995, in the context of her visits to Family X with Ms Kathleen O'Sullivan, Nurse Counsellor for Parents of Children with Mental Disabilities/Advisory Nurse for the Mentally Handicapped. This was at a time when Ms O'Sullivan was making arrangements for Grace to attend a day placement at Day Service Provider A. Ms Hawe said that she felt that Mrs. X was *"a little bit protective of her"* when she was leading her into the room with them. She recalled that Mrs. X was *"resisting"* the proposal for Grace to attend Day Service Provider A. However, Ms Hawe told the Commission that she had no concerns about Grace.¹³
- 3.33 An aspect of the evidence of Ms O'Sullivan, which arose from a conversation that Mr. Iain Smith, Social Work Team Leader, HSE had with her on 21st August, 2007 concerning Grace's case, is reported upon in Volume 1 and in Chapter 2 of this Volume, and is repeated here for ease of reference.
- 3.34 On 21st August, 2007, Mr. Smith recorded that he met with Ms O'Sullivan when she was on her way to a meeting and discussed Grace with her. He wrote that Ms O'Sullivan told him that she had visited Family X several times and had noted Mrs. X's *"rough manner"* with Grace.

¹¹ See Chapter 6 of the First Substantive Interim Report, paragraph 8.48.

¹² Reported upon in Chapter 6 of the First Substantive Interim Report.

¹³ Reported upon in Chapter 6 of the First Substantive Interim Report.

- 3.35 Ms O’Sullivan could not remember the details of their conversation. She disputed Mr. Smith’s record of her describing Mrs. X as having a *“rough manner”* with Grace. She acknowledged that she had said previously in evidence that Mrs. X was *“a little bit rough”* with Grace when she was trying to take down her nappy but she said that what she meant was that she was matter of fact or *“unemotional”*. She said that she would have reported it immediately if she had thought that Mrs. X was rough or abusive with Grace. The Commission accepts Ms O’Sullivan’s evidence in that regard.
- 3.36 In relation to Ms O’Sullivan’s evidence, Mrs. X told the Commission that she sometimes dealt with Grace in a matter-of-fact way. She agreed that Ms O’Sullivan was *“probably”* right in that respect, but she denied ever being rough with Grace. The Commission did not receive any evidence concerning the use of excessive force in the handling of Grace by Mrs. X or by anyone else in the Family X household, in the course of its investigations into Grace’s care.
- 3.37 Ms Leyshon was the social worker and health board employee who had by far the most pro-active involvement in Grace’s case from March, 1999 to May, 2001. Her role in Grace’s case has been reported upon in the Second Substantive Interim Report. Her view at the time of her involvement in Grace’s case was that she had been cared for by Family X for 11 years by that stage and that *“they had a strong attachment to her and she appeared to show an attachment to them.”*
- 3.38 In her evidence with respect to a home visit on 30th September, 1999, Ms Leyshon noted that Grace sat passively in the other sitting room while she was there and that she seemed to become upset when Mrs. X was upset, and to have been quite pleased when she (Ms Leyshon) was leaving. She noted that Grace appeared well: her hair was nicely plaited and she was dressed adequately and looked clean. There was nothing with respect to Grace’s appearance that gave rise to concern on her part.
- 3.39 With regard to the relationship between Mrs. X and Grace, Ms Leyshon felt that Mrs. X showed affection to Grace. She said that there appeared to be *“an attachment to some degree on [Grace’s] part.”* She explained that apart from her brief encounters with Grace and Mrs. X, she had information available to her from Day Service Provider A whose staff, she pointed out, saw Grace on a daily basis and had contact with Mrs. X in relation to her care. She said that what she gleaned from that was that

Grace's care *"appeared to be satisfactory for the most part"*, although there were *"some niggles about certain issues in terms of Mrs. [X's] not really working in partnership [with the day centre]"*. Nonetheless, she said that *"[i]t appeared that [Grace] was cared for adequately at that time."*

- 3.40 The above observations of Grace in her placement with Family X (albeit limited) did not raise any concerns or provide evidence that she was being subjected to emotional abuse.

The period from June, 2001 to August, 2007

- 3.41 As previously reported, no official of the SEHB/HSE visited Grace or the placement or had any interactions with Family X or Grace between June, 2001 and August, 2007. The failures of the SEHB and the HSE in their duties and obligations to Grace in this regard have already been reported in the Commission's Second Substantive Interim Report.

The period from August, 2007 to July, 2009

- 3.42 Volume 1, which deals primarily with the management of Grace's case over this particular period, reports in detail upon the concerns about her care and her placement that were raised within the HSE over the period from August, 2007 to the time that she was moved in July, 2009. These concerns are also considered in other chapters of this Volume. While the concerns raised about Grace in part touched upon aspects of the definitions of emotional abuse contained in guidelines and policies of the sort referred to above at Section 2, these concerns did not identify particular interactions evidencing emotional abuse of Grace in her placement.
- 3.43 There was limited evidence from HSE personnel with regard to observations of Grace in her placement over the above period. The two visits of Mr. Smith and Ms Eileen Griffin, Liaison Social Worker, HSE to Mrs. X's house in September, 2007 and June, 2008 are reported upon in detail in Volume 1. With regard to the question of how Grace and Mrs. X communicated or related to each other, Mr. Smith recorded in his note of the first visit that Grace appeared to be *"smiling and excited"* during their visit and he observed that Mrs. X was *"very appropriate with her"*. He noted that Grace stayed very close to her throughout the visit.

- 3.44 Ms Griffin agreed with Mr. Smith's note in this regard and she said that there appeared to be warmth between Mrs. X and Grace. She recalled Grace as "*holding* [Mrs. X] *quite a bit*" and described Mrs. X as "*very protective*". She said that Mrs. X was "*brushing* [Grace] *a lot*" and that they kept close. In her evidence, Mrs. X said that Grace was accustomed to stay close to her.
- 3.45 Mr. Smith's note of the second visit in June, 2008 recorded that Mrs. X met them when they arrived and called Grace, who came out and sat next to her. Grace appeared to be smiling and shook hands with them, and Mrs. X told him that they were going shopping afterwards. Mrs. X's upset at the news conveyed at that meeting that Grace was to be moved, is reported in Volume 1.
- 3.46 The only other occasions upon which Grace was observed in the placement over this time period was when she was brought home after the two hospital visits in August, 2008 and March, 2009. Both of these occasions are reported upon in detail in Volume 1 and, respectively, in Chapters 2 and 4 of this Volume. There was no evidence arising from those occasions that indicated that there was emotional abuse of Grace and a closeness between Grace and Mrs. X was observed.
- 3.47 The Commission notes that there were, of course, obvious limitations with respect to the sort of observations that could be made about conduct towards or communications with Grace, during expected visits by social workers of the SEHB or the HSE. Nonetheless, the evidence contributed to an overall picture on the question of Grace's relationship with Mrs. X in the household.

Hospital visit: 20th August, 2008

- 3.48 As reported in Volume 1 and in Chapter 2 of this Volume, bruising under Grace's right eye was observed in Day Service Provider A on 20th August, 2008, which led to her removal to the Emergency Department in Waterford Regional Hospital for examination. She was accompanied there by Mr. Smith, Ms B, and Ms D.
- 3.49 When the examination had concluded, Mr. Smith and Ms B returned Grace to Mrs. X's house at approximately 7.30 p.m. Ms D did not accompany them there.
- 3.50 Mrs. X's evidence on the events of this day was very confused, because she appeared to conflate this hospital visit with one which took place in March, 2009,

which is reported upon in Volume 1 and in Chapter 4 of this Volume. Giving her evidence, Mrs. X recalled Grace as being “*very upset*” on her return home and said that she “*came in to me, put her arms around me and cried for being away.*” She said that Grace stayed with her then, telling them Commission that “*I couldn’t get rid of her...[s]he was so happy to be back.*” Mrs. X became emotional in recalling this in her evidence at the Commission. Mrs. X said that she gave Grace a bath and put her to bed and that Grace was “*very happy*”. However, Mrs. X subsequently acknowledged that this account related to the later hospital visit in 2009.

Hospital visit: 27th March, 2009

- 3.51 On the morning of Friday, 27th March, 2009, bruising and scratches to Grace were observed in Day Service Provider A. Later that day, she was taken to Waterford Regional Hospital for examination by Mr. Smith, Ms B, and Ms D. Details of the events of this day are reported upon in Volume 1 and also in Chapter 4 of this Volume. Grace was examined in the Sexual Assault Treatment Unit (the “SATU”) of Waterford Regional Hospital that evening, before being returned to Mrs. X’s house by Mr. Smith, Ms B, and Ms D, where they had a brief conversation with Mrs. X, leaving shortly afterwards.
- 3.52 According to Ms B’s note of the events of 27th March, 2009, the conversation with Mrs. X took place in the sitting room of Mrs. X’s house and Mrs. X held Grace’s hand for the duration of it. Ms B’s note recorded that “[Grace] *walked towards [the] door out of sitting room (left of [the] house), [Mrs. X] held her hand and asked her how she was. [Mrs. X] held [Grace’s] hand for [the] duration of conversation in [the] sitting room*”. Ms B also recorded that, as she, Mr. Smith and Ms D left Mrs. X’s house shortly after midnight, Grace went into the room to the left of the sitting room and that Mrs. X shouted after her twice to “*turn on the light in there [Grace]*”.
- 3.53 Ms D remembered being in the house, but she did not remember the details. She recalled Mrs. X as having dealt with them in a “*matter of fact*” manner and that she had not been defensive. She did not remember Mrs. X’s holding Grace’s hand.
- 3.54 In the context of giving evidence on the matter of the hospital visits, Mrs. X told the Commission that Grace often sat on her lap and cuddled her and that it was particularly with her that Grace did that, which she said she had understood was an illustration that Grace loved her. Mrs. X said that Grace would come to her if she

was tired or upset and look for comfort from her, adding “[s]he would always come to me if the lads were acting [up] on the bus or somebody was getting at her, she would come to me and...[s]haking her hand like that” (indicating). Mrs. X said that Grace would “dance on the floor...and catch my hands...[a]nd try to tell me...there was something wrong.” Mrs. X recalled how Grace would always “jump on her feet” and that she would come to her when there was something wrong. In this regard, Mrs. X said: “[l]ike any kid would go to their mother, they would go for comfort, she used to come to me.”

- 3.55 In conclusion, the Commission did not receive evidence from SEHB or HSE personnel involved in Grace’s case which indicated that she had in fact been subjected to emotional abuse or to a pattern or regime of emotionally abusive behaviour while in the care of Mrs. X.

Contact with other service users who stayed with Family X

- 3.56 The Commission made contact with a number of service users who had stayed with Family X at the same time as Grace and whom it considered might be able to provide useful information about Grace’s care there during that period.
- 3.57 In that regard, the Commission identified and contacted a number of service users who had stayed with Family X in 1989 and 1990 under the Holiday Placement Scheme. None of the service users who responded to the Commission was in a position to provide any material information about Grace in her home setting with Family X.
- 3.58 The Commission also had evidence from a number of persons unconnected with the Holiday Placement Scheme who encountered Grace in her placement and who had some memory of her there. This comprised evidence from three families of individuals who had stayed in the house over different periods when Grace lived there.

The Q family

- 3.59 Mr. and Mrs. Q had a daughter with profound special needs and around 1992, when they were seeking respite when she was 12 years of age, they came into contact with Mrs. X. Mrs. Q said that their daughter, Q.Q., took to Mrs. X “straight away.” She

originally stayed with Mrs. X for a day and a night and Mrs. Q said that that worked out “*very favourably.*” Q.Q. stayed with Mrs. X for periods during the week from 1992 until 2013.

- 3.60 Mrs. Q said that she met Grace all the time when she visited Mrs. X’s house, but she went on to say that she might not have seen her in quite some time prior to her removal from Family X. However she said that “[t]o me [Grace] was as *she always was, I never saw any difference in her.*” She recalled Grace as being non-verbal, always very clean and well-dressed (adding “*I could stand by that*”), with her hair perfectly in a plait. Mrs. Q said that Grace’s skin was poor and that she had acne. When she was asked if she had any other specific recollections, Mrs. Q said that “[o]ther than the fact that [Grace] was always sitting there, just sitting there playing with her keys. I never really remember her doing anything else”. She said that Grace did not interact, recalling that Grace and her daughter sat together on the sofa without any great interaction. However, Mrs. Q said that they had their own way of interacting, both of them being non-verbal.
- 3.61 Mrs. Q also recalled that Family X regularly went for drives, saying that they went shopping to a nearby town. She said that Family X went for a Chinese meal on a Saturday, and that Grace was always in the car with her daughter. When she was asked what she could recall of the house, Mrs. Q mentioned that it was “*a quaint, old house but very warm and inviting. Always fires lit. Welcoming. Old, but welcoming.*”
- 3.62 Mr. Q worked away a lot. He told the Commission that he could not recall going to Family X’s in the very early stages of Q.Q.’s staying there, but said that he certainly was there on occasions. He explained that he used to have to leave for maybe six to eight weeks with work, and that if Q.Q. was with Mrs. X he would visit to spend some time with her. Mr. Q met Grace on such occasions, recalling that she was there frequently in the house when he visited his daughter. He said that Grace was in a little world of her own. She played with her keys or maybe some other toy. Mr. Q recalled that if his daughter happened to grab the keys, Grace would quickly grab them back. To him Grace seemed “*very well cared for, well dressed and well looked after.*” She did not seem in need of anything and appeared to be quite happy. His evidence was that this impression of Grace continued throughout the time that he encountered her.

Ms P

- 3.63 Ms P worked as a personal assistant to Q.Q. from 1999. She collected Q.Q. at Family X's house five days a week, from 1999 to 2013, but she did not go into the house very often. She recalled the one occasion when she met Grace, saying that she was at the house around 2005 when Grace was getting off the bus and that she made a comment to Mrs. X along the lines, "*Oh, she's lovely... Oh, is that [Grace]?*" because she had never seen her before. She said that the next evening she was invited into the house by Mrs. X to meet Grace. Ms P said that she remembered her initial impression of Grace so well. Her first thought was that she was beautiful, with kind of blonde fair hair. She mentioned in evidence that Grace had acne. Ms P recalled that she had a red jumper on and was sitting at the table shaking her plastic keys in her hand. She said that Grace's clothes were really clean and that her hair was freshly washed. Ms P said that she just said hello to Grace and that it was a brief meeting.

Neighbour A and family

- 3.64 A neighbour of Family X's, Neighbour A, had a daughter, A.A., who was born in 1982. She did not have an intellectual disability. A.A. told the Commission that she stayed with Mrs. X during the day from the age of around three till she was seven. She said that she and her sister also stayed there overnight on a couple of occasions. Her mother, Neighbour A, worked part time and needed a child minder. Neighbour A said that this would have been between the hours of 9.00 a.m. to 1.30 p.m. with the number of weekdays varying depending on her work which was sporadic. While she thought that Mrs. X had ceased minding her children in or around 1988 or 1989, she said that:

"I wouldn't be able to say they weren't ever being minded but it was less of a regular event because I was at that stage more at home than I was previously. Also it was more regular, whereas previously it would have been sporadic, my employment would have been sporadic".

- 3.65 A.A. remembered two girls (one of whom was Grace) who had disabilities staying with Family X when she was there. She said that it was the first time that she had had an association with someone who was severely disabled. A.A. recalled that Grace and the other girl did not directly interact much with her and she thought that

this was possibly because of their disabilities. She remembered that from time to time, Mrs. X would have been giving Grace dinner or tea or have had her outside if it was a nice sunny day. She said that Grace *“was sort of, I suppose, I would describe as maybe in her own world and we were doing what young kids did in terms of playing or whatever.”*

3.66 When she was asked about her recollections of Mrs. X, A.A. said that she was *“quite straight or stern, and I suppose she would have been with everybody, I remember her giving out to me but I probably deserved it in terms of being cheeky or bold as a child. She would have been stern as well with the other kids. I wouldn't have said stern in terms of cruel or unfair, strict would be probably the right way, and that would have been across the board.”*

3.67 However, with respect to Grace, A.A. said that *“..my memory of [Mrs. X's] minding her was maybe giving her tea, bringing her outside, obviously helping her to walk outside if it was a nice day, and things like that. She was strict but, as I said, I wouldn't have said cruel or unfair”*. She said that *“I wouldn't have remembered anything that would have perhaps maybe frightened me as a child or any sort of action that I thought: ‘That doesn't seem right’”*.

3.68 A.A. described Mrs. X as slightly more patient with Grace. She told the Commission that *“I remember [Mrs. X] would have given out to me, while her tone may have been as straight with [Grace] I don't remember her ever getting cross or angry or giving out or losing patience at all.”*

Local voluntary association board member

3.69 The Commission also heard evidence from a member of the board of the local voluntary association whose son had stayed with Family X for three consecutive summers from 1987 to 1989. She gave evidence to the Commission of her recollections of Grace in the house. Apart from Grace, her memory was that Mrs. X always had maybe one or two more children in the house.

3.70 The board member said that she remembered vividly her first interaction with Grace in Family X's house. She recalled that when she first saw Grace, which was about four months after she had arrived, her presentation was *“dreadful.”* Grace had curly blonde hair and the board member said that she did not know how one would attempt

to comb it or brush it. She also recalled that Grace was drooling. The board member said that Mrs. X told her that Grace was doubly incontinent. She remembered Grace being covered in a rash and scabs, and told the Commission that she looked “*awful.*”

- 3.71 The board member said that Grace responded very well to Mrs. X. She said that when she went to the house the following weekend, she saw a little change in Grace for the better. She said that, eventually, Grace had no special diet, no incontinence and no rash on her skin. She told the Commission that while Grace did not talk at all, she could communicate and looked happy.
- 3.72 The board member distinctly remembered seeing Grace, which she thought was the following summer, sitting in the back of Family X’s car. She said that there were three children in the back of it and that Grace was laughing and fighting with the child by the window because she wanted a turn at it. It was “*all fun.*” The board member said that Grace had “*a yellow skirt and blue stockings and a pink bow and God knows what else on her, but she was a happy child.*” She said that she also saw huge changes in Grace’s expression and her face, as well as in her physical condition and in what she termed her devotion to Mrs. X.
- 3.73 The board member’s impression was that Grace was “*very fond*” of Mrs. X and got on fine with Mr. X.
- 3.74 Referring to her own son and generally to other children on holiday placement in Family X’s, the board member said that “*they all had their own abilities and disabilities and [Grace] blended in.*” Looking back, she remarked that “[t]he only thing I would say there is that [Grace] should have been sent to school”. The matter of Grace’s schooling in the context of her care is reported upon in Chapter 3 of this Volume.
- 3.75 After her son had finished staying with Mrs. X on respite, the board member went occasionally to visit Mrs. X. She recalled that the house remained the very same. When she was asked about Grace’s presentation on those visits, she recalled that Grace “*would kind of hug herself near [Mrs. X] but she wasn’t afraid, or anything, she was just secure when she was with [Mrs. X].*” She said that “[s]he looked fine. She was getting bigger and she was getting not so kind of cuddly, more lanky [kind] of”.

- 3.76 The board member said that Grace had no speech but that she behaved in a very normal way. She recalled Grace's clothes as being "[e]very colour in the rainbow, but nothing dirty". The board member said that she stopped going to see Mrs. X once Grace went to Day Service Provider A, i.e. in September, 1995. She described Mrs. X as also dressed colourfully and recalled her as having blonde, curly, unruly hair.
- 3.77 In describing the house, the board member remarked that "*colourful isn't the name for it, the cushions were every [colour] of the rainbow and the rugs and cushions and sofas and higgledy-piggledy now but no dirt, everything was clean*". In this regard, the board member told the Commission that "*it's atmosphere I wanted, not posh furniture*". She said that when she dropped off her son, she would have to go in and that Mrs. X would put on the kettle. She said that "[s]he might have nothing much to say but she'd babble on...And you'd talk and the house was open."

The local schoolmaster

- 3.78 The involvement in Grace's case of the local schoolmaster of the school attended by Alpha and his making of representations in her case on behalf of Mrs. and Mr. X in 1996, is fully reported in the First Substantive Interim Report.
- 3.79 The local schoolmaster was familiar with Grace. He saw her in the car with Mr. X from the time Alpha attended playschool. He described how Mr. and Mrs. X cared for their grandson who had had a health difficulty and had also lost his mother at a very young age. The local schoolmaster saw the way Alpha and Grace reacted to each other, and said that they were like brother and sister. He observed that there was "*great affection between the two of them*". He told the Commission that, "*it would have been apparent to anybody who would have seen them together that they were very close*".
- 3.80 The local schoolmaster told the Commission that he had also seen this when he called to Family X's home in connection with children's birthday parties and saw Grace with Mrs. X in the front garden. He described what he saw of their relationship at the time as being like that of "*a grandmother or a very loving person that was responding to a person with needs*".
- 3.81 The local schoolmaster described talking with Mrs. X in her front garden and how Mrs. X would stroke Grace's hair and how Grace might have her arms around her.

The local schoolmaster described what he saw as an “*excellent*” relationship between Mrs. X and Grace. When Mrs. X and Grace accompanied Mr. X to the school, he said that he had observed “*great joy or love or care in the relationship they had*”.

- 3.82 The local schoolmaster observed the relationship between Grace and Mr. X to be more formal, but these observations were limited to when Grace was in her seat at the back of the car when Mr. X was driving.
- 3.83 The local schoolmaster said in his evidence that he saw Grace as being in a “*loving environment*” and that he was concerned that she not be removed from it and placed in a child care institution with large numbers of children. The local schoolmaster told the Commission that he believed that Mrs. X was held in high regard by Ms Greaney, whom he knew and who used to call to his house on her way to Family X’s. He believed that Ms Greaney “*looked very highly on [Mr. X and Mrs. X] for the work that they were doing*”.
- 3.84 The local schoolmaster told the Commission that he thought that Grace looked “*fine*” insofar as her presentation was concerned. He said that there was no sign for the local people that there was anything untoward happening or might be happening there. He saw no signs of any physical abuse of Grace. He said that Alpha was coming from the same house and that he was always turned out “*perfectly well*” for school. He said that “*between lunches and whatever*”, there was never any sign of any neglect towards Grace or Alpha.

Dr. F

- 3.85 The evidence of Dr. F, general practitioner, is reported extensively in Chapter 3 of this Volume. Dr. F told the Commission that it was Mrs. X who brought Grace to his surgery the majority of the time. He knew that Mrs. X was a foster carer. He thought that the relationship between Grace and Mrs. X was “*very good*”. Dr. F said that Mrs. X was caring towards Grace when she was in his surgery and that it seemed to be a normal relationship. He said that, like most of his patients, Mrs. X behaved in a way that he considered normal when dealing with a vulnerable child, adding that he always regarded Grace as a child even when she became an adult. When he was asked if he was satisfied that Mrs. X was taking good care of Grace, Dr. F said “[s]he

seemed to be, to me anyway. Absolutely, I had no doubts." He believed that Mrs. X was "*absolutely*" a good historian with respect to Grace's symptoms.

3.86 Dr. F also had a positive view of Mr. X insofar as he encountered him and said that he did not think there was anything abnormal in the relationship between Mr. X and Grace.

3.87 Dr. F also told the Commission that he knew Alpha very well. He said he was "*a smashing young fella...a lovely young fella, in good form, working full time*".

Dr. G

3.88 In his evidence concerning the first occasion that he recalled meeting Mrs. X when she brought Grace to an appointment in October, 2008, Dr. G offered an insight into how Grace and Mrs. X were together. He said:

"The impression I got was that she was a bit, she was kind of confused as to why she was being -- she didn't seem to fully understand why the social workers were so concerned and that she wasn't really sure why they were going to the level of wanting to essentially, as she probably put, take [Grace] away from her.

She had been with her for more than 20 years and I got the impression that I suppose she kind of looked at her like a daughter and she felt like it was like somebody trying to take her child away, that was the impression that I got from it."

3.89 Dr. G also told the Commission that he was aware that Mrs. X did not agree with the move. Dr. G said that that was his overarching feeling that day.

3.90 Dr. G recalled that:

"The day that she came into me -- it was one of the things that I can remember is just that she was -- she seemed slightly upset because she didn't...she had had [Grace] there for, as she said, more than 20 years, and she felt that she was doing a good job looking after her and she wanted to continue doing that. That was just the impression that I

got from her.”

Finding

- 3.91 The evidence to the Commission from the above witnesses concerning their observations of Grace in her placement or her interactions with Mr. and Mrs. X, limited as they were, did not indicate that Grace had been subjected to emotional abuse in her placement with Family X.

Mr. Enda McGovern

Psychological assessment - 1989

- 3.92 As reported in Chapter 5 of the Commission’s First Substantive Interim Report and referred to above, on 3rd August, 1989, when Grace was 10 years old, she was assessed by Mr. Enda McGovern, Clinical Psychologist with the Brothers of Charity. His report stated that she *“seems to be getting on well with the family”* and that she *“appeared to be a child with a happy and sunny disposition, who is enjoying her current stay with [Family X], and they in turn have very positive things to say about [her] ...”*

- 3.93 Regarding the “conclusions and recommendations” in his report, Mr. McGovern stated, among other things, as follows:

“In the short-term I feel [Grace] has profited from her stay with [Family X] who seem to be very caring and positively constructive individuals, who have accepted [Grace] as one of their own.”

Psychological assessment - 2008

- 3.94 Mr. McGovern was asked to assess Grace again in 2008 and this is a matter reported upon in Chapter 12 of Volume 1 and in Chapter 4 of this Volume. In compiling his psychological report, Mr. McGovern met with Grace on 28th October, 2008 for the purpose of cognitive assessment and also had the opportunity to interview Mrs. X on that date. He later saw Mrs. X for a joint consultation with Dr. Nan Ferrari, Consultant Psychologist with the Brothers of Charity, on 31st October, 2008.

3.95 The purpose of his assessment in 2008 was to assess Grace's social, emotional and intellectual functioning with a view to her being moved to a residential placement. He also considered the issue of "attachment" between Grace and Mrs. X, saying that:

"there was some degree of a permanent relationship, if we want to call it that, over a time...that existed and that the movement from [the village] where [Grace] had lived for a lengthy...period of time, to a residential facility would usher in changes for both of them... obviously there would be an element of difficulty for [Mrs. X] and, at some level again, for [Grace]"

3.96 Mr. McGovern observed in his report that:

"... [Grace] appears to understand simple familiar requests and instructions, but in the context of her residential placement in [her village], [Family X] have tended to anticipate her needs rather than [Grace] actually making her needs known."

3.97 Under the heading "Interview - Mrs. [X]", Mr. McGovern noted the following:

"On the initial date 30.09.2008 I gained a background history from Mrs. [X] in relation to [Grace's] typical functioning on a day to day basis within her foster care placement. It would appear that she can manage most self care tasks in terms of dressing, undressing, toileting, etc. She can follow instructions at a rudimentary level, will indicate a preference when offered a choice, shows affection, and is capable of imitating a simple sequence of actions- such as clapping hands, waving goodbye etc. However, her repertoire of skills is quite limited, and unless stimulated or engaged by others – [she] will remain passive, self-absorbed, and tending to engage in repetitive behaviours."

3.98 He went on to note that:

“From Mrs. [X’s] description on this occasion and subsequently when interviewed jointly by myself and Dr. Nan Ferrari (31.10.2008), she describes the situation in which [Grace] lives as secure and comfortable in the context of her placement [in her village]. One gets the impression from talking to Mrs. [X] that she has made her best efforts within her particular circumstances and that some of the difficulties have arisen because of a degree of mutual misunderstanding and mistrust between herself and personnel in the HSE.”

3.99 Mr. McGovern also observed that:

“At stages during the interview with her, [Mrs. X] became somewhat emotional and conveyed a sense that she had a genuine interest and commitment to her care of [Grace] treating her as if she were her own daughter.”

3.100 Mr. McGovern recorded in his report that they also examined issues with regard to Grace's quality of life and how best to address her social and emotional needs within the context of a group home and a programme where she would have her own peer group. In this regard, Mr. McGovern noted in his report that Mrs. X was *“very aware of some of these unmet needs and also willing to consider the desirability for a planned approach to [Grace’s] future care, even if it was in an alternative facility to that of [Mrs. X’s home].”*

3.101 Mr. McGovern reported that *“I do not envisage that [Grace] will have any difficulty making the transition to the group home, as I feel her attachment to Mrs. [X] is not so significant that she will have any difficulty making that adjustment.”*

3.102 Although Mr. McGovern said in evidence that he was reliant on his report and that he could not recall very much with regard to his impression of Mrs. X, he told the Commission that *“I have a sense of someone who seemed, what would I say, genuine enough, plausible and seemed to have a degree of interest in her role as caretaker.”*

3.103 With reference to a note he had made during his assessment: *“Query: too attached to girl”*, Mr. McGovern told the Commission: *“I suspect it is from seeing Mrs. [X] and*

listening to her. She had a greater investment in [Grace] than, you know, [Grace] would have had in her. That is my impression I think from, I am drawing that from it." Mr. McGovern said that this was his observation, and not something that Mrs. X had put forward during the interview or something that was discussed during the interview.

3.104 On the question of attachment, Mr. McGovern said that:

"I suppose attachment in the broad sense here, I'm referring to the fact that someone with a profound intellectual disability and I am specifically talking here about [Grace] who, if you look at her early history, had quite a fractured and a wide range of other placements prior to coming to [Family X], but also someone with a profound intellectual disability cognitively, I don't think they are capable of the same type of attachment as someone who is functioning at a higher level. The type of relationship which Mrs. [X] would have had with her and [Grace] enjoyed was one more of dependancy in terms of someone answering her needs, anticipating her needs, et cetera. I suppose when we think of attachment we think of something which is reciprocal, which involves an emotional investment by the caretaker and also by the person who is being cared for. So, that is mutual, it is reciprocal and it develops over time. With someone who has a profound intellectual disability who has, in a sense, plateaued intellectually and they wouldn't have the same degree of investment emotionally in that type of relationship. So, I suppose, I'm talking about that in the broad sense, attachment is here."

3.105 Commenting further on the level of attachment between Mrs. X and Grace, Mr. McGovern told the Commission the following:

"I think with someone who has a profound intellectual disability and also given the history in advance before she was placed [in the village where she lived with Family X] [Grace] has a very fractured experience of placement, she was in at least three other placement homes before she came to [Family X] at a particular stage, at a fairly critical stage when, I suppose, a lot of the bonding and attachment happens, so that, in a sense, was interrupted at one level."

At another level the type of relationship she entered into with Mrs. [X] was one of dependency, think about profound and I suppose the word tells you everything, profound intellectual disability describes it very much as it is. She is profound...

It is a multi-faceted. It is very much a series of associated deficits, whether physical, sensory or other, so you have someone who has a rather limited understanding, a limited cognitive ability so that making the kind of emotional investment in a relationship requires a sense of other, requires a sense of knowledge of the other person external to me."

3.106 He went on to say that:

"I think if we think about a young child we think in terms of someone who forms a mutual understanding at an emotional level with an adult and it is reciprocal. That is a process which operates over time and is built on. I would suggest certainly from anything I have read and research, which is fairly thin on the ground, that for [Grace] the type of relationship she had was one of dependency, so in a sense that her needs, she would signal Mrs. [X], or whoever else was her caretaker, would respond more out of a sense of the day being patterned and very much routine. She is someone by virtue of her biological needs, whether it is toileting, whether it is sleep and other areas is tending to be quite, I suppose, programmed, and a lot of her learning is reflexive, a lot of her learning is on the basis of conditioning, it is an old word we would have used years ago, it is very much built upon the basis of conditioning. I would also say that a lot of her learning is on the basis of over practice and repetition. This has taken years to build up simple skills, whether they be dressing, undressing, toileting, et cetera. These are incremental and these are step by step. If we go back to the previous notion of transition and moving into alternative accommodation it has to be built up on a very incremental basis. I suppose at the core of this you have someone who needs inbuilt support, you [need] lots of structure and a lot of very intensive individualised help."

Dr. Nan Ferrari

- 3.107 The evidence of Dr. Nan Ferrari, Consultant Psychiatrist, with respect to her involvement in Grace's care is substantially reported in Chapter 4 of this Volume.
- 3.108 With regard to her attendance at the appointment with Mr. McGovern and Mrs. X on 31st October, 2008, she said that "[a]ll I recall is my general impression that Mrs. [X] cared, genuinely cared for [Grace], and would be sorry to, would miss her if she went into residential care. That is the recall of what I remember."
- 3.109 Dr. Ferrari also observed that "...she [Mrs. X] was concerned about missing [Grace] and the loneliness for her of letting [Grace] go into residential care... I think that was the strongest emotion that I could see."
- 3.110 Asked about Mrs. X's level of concern for Grace, Dr. Ferrari said: "*I don't think I thought it was inappropriate in any way... I pretty much felt it was normal I think... [t]hat she was concerned that she would miss [Grace].*"
- 3.111 Dr. Ferrari said that, just as Mr. McGovern had noted in his report, she too formed the impression that Mrs. X had made her best efforts in dealing with Grace in her particular circumstances. Dr. Ferrari said that this impression was based, not on anything that Mrs. X said or did during the appointment, but generally on the way that Mrs. X spoke about Grace and on "[t]he way she spoke about living with [Grace] for 20 years and, you know, the relationship they had and the fact that she would miss her if she moved."
- 3.112 With reference to the part of Mr. McGovern's report where he noted that Mrs. X was aware of some of Grace's "*unmet needs*", Dr. Ferrari said that "*I thought that while she was quite upset at the thought of [Grace's] going away from her that she seemed to be on board with our recommendations, to go with it.*"
- 3.113 The above evidence was of assistance to the Commission in providing an impression of the nature of the relationship and Mrs. X's views as expressed at this time.

4. Grace's attachment to her plastic keys and the question of punishment or discipline

- 4.1 Grace's attachment to a plastic set of toy keys was referred to frequently in the evidence to the Commission. These were an item of comfort for her. An issue arose in the evidence as to whether they were taken from her by Mrs. X or in Day Service Provider A from time to time and as to the circumstances in which this occurred.
- 4.2 The Commission heard evidence of Grace's attachment to these keys, both from Family X and from Day Service Provider A staff. When Grace came to live with Family X in February, 1989, aged ten, she came in the clothes she wore, holding a set of plastic play keys. 20 years later, when Grace was moved from her day placement in Day Service Provider A into a residential placement at the age of 30, she was holding a similar set of keys. Over the intervening period, Grace was rarely parted from her plastic keys. Her attachment to them continued at the time of the Commission's investigations.
- 4.3 In her evidence, Mrs. X said that when Grace first came to live with Family X, she had a set of plastic keys, with which she refused to part. Mrs. X said that Grace would not give the keys away to anybody. She said that Ms Greaney told her that *"whatever you do, don't take the keys"* because, if she did, she would not have *"a minute's peace"*. However, Mrs. X gave contradictory evidence on this point, also saying that Ms Greaney had advised her to remove the keys as a means of punishing Grace, in effect, that removing them could be used as a form of discipline. This is referred to further below.
- 4.4 Mrs. X said that she bought Grace teddy bears and dolls but that Grace would throw them on the floor. She said that people also bought her presents and that she would throw them on the floor too. By contrast, she would not part with the keys for anyone. She said that Grace was *"really happy all the time when she had her keys"*.
- 4.5 In the course of her evidence, Mrs. X recalled losing the keys in a restaurant one day and being unable to find them. She said that they bought Grace the same keys but that she was not happy with them. Mrs. X said *"there [was] murder"* and that Grace screamed and shouted. Mrs. X recalled that it took Grace a couple of weeks for her to get used to the new keys and said she made sure that they were never lost again.

- 4.6 Alpha remembered from the days of his childhood that Grace's keys could never be apart from her. She got agitated if they were mislaid or if somebody took them from her. He said that Grace made a noise or a kind of sign to say that her keys were not with her and that he knew immediately what it meant. Alpha had no recollection of Grace's having any interest in dolls or teddy bears or Lego. He recalled that she would sit playing with the keys when at the television.
- 4.7 Gamma also said that the keys were all Grace ever played with. He said that Mrs. X tried everything with her. She gave her things but that Grace "*didn't want to know.*" Gamma said that Grace was happy in her own company and he described her as a "*loner.*" Gamma told the Commission that Grace did not like other children and he believed that one of the reasons for this was because she thought that they would take her keys and she did not want that. He said that she did not seem to do much and, speaking of the times that he was there, said that she only sat in the chair playing with the set of plastic keys, either two or three of them on a ring, all of the time.
- 4.8 This description of Grace as liking or tending to sit on her own was echoed in other evidence heard by the Commission.¹⁴
- 4.9 Grace's apparent lack of interest in material things was something that was noted by Ms B in the weeks following her move into her residential placement in July, 2009. At that time, Ms B noted that, when asked, Mrs. X stated that she had clothes belonging to Grace. Ms B recorded that she told Mrs. X that new clothes would be purchased for Grace, since she did not have any of her own, to which Mrs. X responded that "*those material things*" meant "*nothing*" to Grace and that Grace had been happy living with her. Ms B recorded Mrs. X as then saying "*I loved her, I always will.*"

¹⁴ Ms Helen O'Brien, SEHB Social Worker for Adults with Intellectual Disabilities, who was appointed as Grace's "key worker" in October, 1996 recalled seeing Grace in Day Service Provider A during this period (there were no records provided to the Commission of any such visits). Ms O'Brien could not recall whether she had spoken to Mr. M or any of the other staff members in Day Service Provider A at the time about Grace but she said that, on those visits, her impression was that Grace was "*a bit of a loner*".

In preparation for the case conference on 27th January, 1989 the Sister-in-Charge at the Wicklow School wrote a report about Grace. The report, set out in full in the First Substantive Interim Report, also described Grace in these terms ("*still a loner*"). A consultant psychiatrist carried out an assessment of Grace in 1989. His note of this recorded that she had "*settled in well*" and described her as "*a bit of a loner*" who, nonetheless "*mixes well with other children both normal and handicapped*" whom Mr. and Mrs. X minded from time to time. The note recorded that Grace was "*a very affectionate child*", especially towards Mrs. X.

On 21st May, 1998, a form was completed in relation to Grace which gave a detailed outline of her situation at the time, including her medical information, care requirements, daily routine and likes and dislikes. The form noted that Grace "*becomes disturbed*" when there was company and later described her as a "*loner*". It was noted that "[a]t home she never wets. For the last 4 months she has done so at the workshop?". The form was signed by Mr. X.

According to Mrs. X's evidence, Grace was a loner.

Grace's scratching herself with her keys

- 4.10 As reported in Chapter 2, Grace suffered from *acne vulgaris*, a skin condition that caused her irritation from adolescence into adulthood. As a result of this, she was prone to scratch herself with her plastic keys. There were reports of her sometimes scratching herself with them. The Commission heard evidence of Grace's scratching herself with the keys regularly at home, on the Day Service Provider A bus, and also during the day at Day Service Provider A.

Mrs. X's evidence

- 4.11 During her evidence, Mrs. X spoke about how that Grace used to "*bang*" and scratch herself using the plastic keys that she carried, including when she slept at night-time. This was also witnessed by Gamma (Mrs. X's nephew) and Alpha (her grandson) and at Day Service Provider A, where it was variously described as banging or tapping.
- 4.12 According to Mrs. X, Grace tended to scratch her face, teeth, gums, ears, back, and chest. Mrs. X said that she used to cut Grace's fingernails in order to prevent her from scratching her skin.
- 4.13 Mrs. X initially said that Grace's scratching did not lessen with the passage of time. However, she subsequently indicated that, although her scratching had eased somewhat by the time she turned 20 years of age, it was still something that she engaged in after that time. When Grace scratched herself in bed at night, Mrs. X said, there was nothing that she could do to stop her. Mrs. X recalled how Grace could begin to scratch herself for no discernible reason.
- 4.14 In addition to scratching herself, Mrs. X told the Commission about Grace's tendency to bang her teeth and her ears with the plastic keys, adding that this would sometimes result in bleeding from her gums or from her ears. Mrs. X also said that Grace sometimes had blood in her nose and eye areas, which she said was as a result of her scratching herself with the plastic keys, and which she said "*often happened*".
- 4.15 Mrs. X told the Commission that she sometimes took the keys from Grace but that this did not stop her from scratching herself, adding that Grace would sleep through

the night as long as she had her plastic keys. The issue of how Grace's plastic keys were managed is reported upon below.

Alpha's evidence

- 4.16 In giving evidence to the Commission, Alpha said that Grace tended to scratch herself with the plastic keys and that this scratching and "*tipping*" of the keys against her teeth had, at times, caused her gums to bleed.

Gamma's evidence

- 4.17 Gamma recalled seeing Grace with the keys and her "*prodding*" her gums with them. He also remembered seeing her "*stick [the keys] in her teeth*", describing her as "*tipping away*". He said that this caused her gums to bleed. Gamma said that he did not see Grace scratch any other part of her body with the keys and that he did not see any scratches on her that were in any way "*out of the ordinary*".

Beta's evidence

- 4.18 Beta did not remember seeing scratches on Grace. Nor did he recall ever seeing her scratch herself with the keys or put them to her mouth.

Mr. M's evidence

- 4.19 Mr. M did not recall ever seeing Grace use her plastic keys to scratch herself, but added that this was not to say that it did not happen. CW1, who was initially employed in 1997 as a care assistant at Day Service Provider A and then went on to work there as a programme assistant and as a programme supervisor, recalled that Grace suffered from acne but she did not recall her scratching her acne using her plastic keys or otherwise. Her recollection was that she only held the keys "*up near her eyes.*"
- 4.20 Particular occasions when scratches were noted on Grace are considered and reported upon in Chapter 2 of this Volume.

Removal of keys from Grace

- 4.21 The issue of Grace's keys being removed from her was noted on her attendance at Day Service Provider A. This is reported in the First Substantive Interim Report. Mr. M's report of April, 1996, detailing Grace's behaviour in the first seven months in Day Service Provider A, set out that:

"[Grace] always carried a bunch of coloured keys - as a pacifier. But when her foster parents were notified, by the drivers, of her behaviour on the bus, the keys were withdrawn as a form of punishment. This action made the situation more intolerable for us - her outbursts and behaviour got exceedingly worse. At this juncture, [Grace] took to stripping off all her clothes both on the bus and at [Day Service Provider A]. When this happened, the pacifier was returned. Now after seven months of constant supervision and care, the situation is gradually improving. [Grace] no longer presents with so many problem[s]. Doors remain open and there is no threat of [her] running away. Head-butting, screaming, stripping off, all these behaviours are no longer manifested."

- 4.22 Mr. M described how these keys went "everywhere" with Grace. He said that the staff in Day Service Provider A were aware that it would cause her to become agitated if they were removed from her. He said that if someone took the keys from her, or if she lost them, *"the shouting and screaming in [Day Service Provider A] would be heard by everybody"*. He said that this would have a knock-on effect and others would get upset and agitated.
- 4.23 CW2, a programme assistant at Day Service Provider A, also said that Grace had her keys all of the time and that they could not be taken from her because they calmed her. CW1 also recalled that Grace carried and rattled her keys and was *"very comfortable"* when she was doing that.
- 4.24 CW2 recalled that Grace sometimes came to Day Service Provider A without her keys. She said that if Grace misbehaved, banged her head, soiled herself, or was incontinent of urine, Mrs. X would take them off her because she was *"bold"*. She said that Grace became *"very distressed"* when this happened. CW2 said that she knew how important the keys were to Grace.

- 4.25 CW2 also said that Mrs. X occasionally took the keys from Grace to stop incidents occurring on the bus. She had recorded a specific instance on 26th February, 2007 when Grace did not have her keys, as follows:

"[Grace] came back from a long absence today. Went bowling. Didn't have her keys with her. [Mrs. X] rang up to enquire how [she] got on. I told her she got on grand. [Mrs. X] explained how she is keeping the keys at home in an attempt to calm [her] on the...bus. She explained to [Grace] that she will get the keys back when she gets home".

- 4.26 However, CW2 did not recall this incident at the Commission.

- 4.27 CW4, a programme assistant at Day Service Provider A, likened Grace's attachment to her keys to a child with its blanket or its "dummy". She recalled Grace's having the keys in her hand and tapping them at her mouth.

- 4.28 In a note from 20th November, 1995, at the early stage of Grace's attendance in Day Service Provider A, Nurse N wrote to Mrs. X stating that Grace was in "[v]ery bad" form that day. Grace was apparently "[s]hout[ing] + screaming all day [and] running in and out of [the] room." Nurse N wrote that "[n]othing seemed to pacify her". She suggested to Mrs. X that it was probably because of the keys (which Grace used as a pacifier and which, given the context of the note, would appear to have been withdrawn by Mrs. X) and expressed the hope that everything would be all right when Grace arrived home. Mrs. X could not recall this correspondence but did remember that Grace would "go mad" without the keys. Her memory was that she took the keys from Grace over something to do with Day Service Provider A.

- 4.29 An undated handwritten note from Mrs. X to Nurse N, which dated from some time between 1995 and 2000, and was prompted by a telephone call from Nurse N, stated *inter alia* "Regarding the taking off her shoes and clothes this is something that has only happened since going to the work shop. What the answer to all this is I just dont know. To-night we gave her a real telling off so lets hope it will have some effect." It continued by stating: "Have given [Grace] her keys back" and expressing the view that "[t]he psychiatrists were right when they told us [Grace] was not suitable for the workshop or school. With her assessed mentality of an 18 month child its no wonder."

- 4.30 Another undated note from Day Service Provider A, which from its contents was written in or around 1999, recorded that “[Grace] was *bold on Sunday* so [Mrs. X] took the keys from [her], as she had been told by [Mr. M] that when she is bold that she is to be punished and that is to take her keys...[Grace] has her keys with her today (Friday). [Mrs. X] has said if [Grace] is bold, she will never take the keys from her again, that she will find some other way of punishing [Grace]. But most of the time [Grace] is very good...”
- 4.31 Another undated note from Mrs. X to Nurse N, which according to its content was written in or around 1995, stated *inter alia*: “Sorry about [Grace’s] wetting herself to day. I am sending in some spare clothes in case it happens again. I hope she is not going back to be as she was when I first had her six years ago. I am giving her back her keys to see if this will help” (Mrs. X concluded the note by stating “the box contains a few goodies for the party on Friday. Will send the cake in Friday morning. Thanks again for everything.”).
- 4.32 As reported upon in the First Substantive Interim Report, Mrs. X recalled taking Grace’s keys from her when she learnt of her conduct on the bus. She said that this was done on the advice of Ms Greaney who had told her that it was the only punishment that would be effective. Mrs. X likened Grace’s initial behaviour in Day Service Provider A to behaviour she exhibited when she arrived to stay with Family X in 1989. She attributed this to the fact that Grace did not like change or changes of scenery. Mrs. X told the Commission that when Grace arrived in 1989, it took her approximately four weeks to settle in.
- 4.33 Mrs. X also said in evidence that she used to take the keys from Grace if she “was bad at [Day Service Provider A].” Mrs. X’s evidence on the circumstances giving rise to this and its frequency varied. She said that she only did it “once or twice”, and that it was on Ms Greaney’s advice. As indicated above, her evidence on what Ms Greaney had told her regarding the keys was contradictory. When she was asked if withdrawal of the keys was effective, Mrs. X said that it did not work. She also said that, when she took the keys from Grace, she used to tell her that it was because she had been “bad” in the day service. When she was asked if Grace understood that, Mrs. X said that “it seemed she did.” Mrs. X also said in evidence that she took the keys from Grace on one occasion “because she was scratching too much.”

- 4.34 Mrs. X told the Commission that Grace could shout and scream and make a lot of noise. According to Mrs. X, there would not be a particular time of the day when that happened but that it happened all of the time without advance notice. She said that, if she could not calm her, Ms Greaney had advised her to take Grace's keys from her. As noted above at paragraph 4.3, Mrs. X also gave inconsistent evidence on what it was that Ms Greaney had said to her about removing the keys from Grace. As previously reported, the Commission did not have evidence from Ms Greaney, who had died before the Commission was established.
- 4.35 Mrs. X remembered bringing Grace to the doctor once and said that the doctor told her to take the keys off her, but Mrs. X said during her evidence that she could not do that; that she was told not to do that.
- 4.36 Mrs. X said that, when she took the keys from Grace, she used to kick out badly and bang her head off the wall. She said that Grace would stop of her own accord, and that *"I would give her something, like treat her to something."* She said that she would then give Grace the keys back. Mrs. X said that Grace was always chewing the keys and would knock them against her mouth. Grace also used to scratch herself with the keys and there would sometimes be bleeding as a result.
- 4.37 Gamma also recalled that Grace prodded herself with the keys and that Mrs. X used to get on to her about this. He recalled that, as a child, Alpha used to try and take the keys off Grace. He said that they had a little game between them in that Alpha would take the keys off her and she would take them back off him.
- 4.38 Mrs. X acknowledged in her evidence that taking the keys from Grace was not effective, saying that this was because she loved them so much. She agreed that Grace would get more agitated if they were removed and that it never really worked. She said that she did not take the keys from her often. However, Mrs. X's evidence was inconsistent and contradictory on the question of how regularly this occurred. Having regard to the totality of the evidence, the Commission is satisfied that, in all likelihood, it was a relatively regular occurrence.
- 4.39 It should be noted that, apart from the question as to whether it was appropriate to take the keys from Grace, there were also concerns expressed at what was regarded as the childishness of these keys for Grace. As reported in the Second Substantive

Interim Report, Grace's reliance on her keys was referred to in the minutes of a meeting of core professionals of the SEHB in February, 2001, as follows:

"Mr. and Mrs. [X] do not encourage [Grace] to achieve any level of maturity but rather treat her as a 'baby'. She has a set of plastic keys which she has had since infancy and these appear to have a soothing effect on her. [Grace] is unsettled if they are not in her possession. Mrs. [X] does not allow [Grace] to have the plastic keys if she is 'out of order'".

- 4.40 According to Mr. M, Day Service Provider A was never in agreement with Grace's having these keys in the first place as it was *"very childish"*. He said that they were trying to *"promote the fact that [the service users] were adults, should be treated as adults, and were not reverting back to childish things"*.
- 4.41 Looking back on the issue in evidence he thought that, in Mrs. X's mind, she was taking the keys as a form of discipline for Grace, but in his opinion, this was not a tactic that would have been likely to calm her down.
- 4.42 In the course of his evidence, Mr. M was asked whether it would strike him as a cruel thing to take the keys from someone who was attached to them without that person's understanding why. Mr. M agreed that he could say that. When asked if it struck him as being a form of emotional cruelty, he said, *"I don't know if I analysed it like that or did we ever think of maybe we'll get a second bunch of keys and we'll have them here, that if she loses them on the bus we'll have a set here, we never did that"*. Mr. M remarked that, not only could Mrs. X take the keys off her, but Grace herself could leave them down and they would end up looking for them.

Day Service Provider A's approach to the keys

- 4.43 Differing approaches to this issue of the keys were demonstrated by the following notes from Day Service Provider A.
- 4.44 On 1st March, 2007, CW2 noted that *"[Grace] went into town today. Form very good. Doing very well without the keys"*. CW2 did not recall this occasion at the Commission but said that the keys must have been taken by Mrs. X as Day Service Provider A *"didn't have a policy"* of taking Grace's keys from her.

- 4.45 There was, however, some record of Grace's keys being withheld from her in Day Service Provider A in the following circumstances. On 19th August, 2008, CW7, a programme assistant at the day centre, made a note of a trip by Grace and other service users into town with CW2. According to the note, Grace was in good form. She stayed dry in town; however, she was very excitable. CW2 took the keys off Grace before she had her tea and this seemed to calm her down. Grace then went the rest of the day without asking for her keys and she got them back before going home.
- 4.46 CW2 could not recall this occasion in her evidence. She explained, however, that they took Grace into town on occasion and that she sometimes "*would make a burst*" towards people in order to get tea. She surmised that, in those circumstances, she had taken the keys and put them in her pocket in order to try to calm Grace down but she did not recall for certain. She could not recall if she took Grace's keys from her often.
- 4.47 An entry from Day Service Provider A's daily diary for Grace dated 18th November, 2008 stated that she stripped off all her clothes twice in the bathroom. An entry on 19th November, 2008 recorded Mrs. X's response to that, namely that Grace "*never takes her clothes off at home. Only when she is told at Bed/time. Take her keys when she does that again. She will soon learn. Thanks [Mrs. X]*" (emphasis as in note).
- 4.48 CW2 thought that while Grace was attached to her keys, it was not until after she moved to her residential placement that they became "*an issue*", i.e. that she became "*very, very attached to them*". The traumatic impact on Grace of her move into residential care is reported in Chapter 4 of this Volume.
- 4.49 In her evidence with respect to this note, CW7 said that Grace would be almost "*hyper*". She said that she might dart for people or stand up out of her seat. If it escalated she would become vocal. CW7 did not recall that it was normal practice to take Grace's keys; however, they encouraged her to put them down at times during activities and if she was going to the toilet. She was aware that the keys were a comfort for Grace and that she always had them with her.
- 4.50 When Ms D became involved in Grace's case upon taking up the role of manager of the day centre at the end of March, 2008, she had some conversation with Mrs. X about Grace's keys. In a record made by Mr. Smith of a conversation with Ms D on

17th June, 2008, he noted that she *“was concerned in regard to the set of toy keys that [Grace] had, and their use as reward and punishment.”* Ms D did not recall that aspect of their conversation in evidence but she said that Mrs. X told her during a conversation that she had been advised by someone, whom she did not specify, to take the keys away from Grace. Ms D thought that that related to situations where Grace was incontinent. She said that Mrs. X did not say that she took the keys from Grace, just that a social worker had told her to do so. Ms D said that she must have had that conversation with Mrs. X before she spoke to Mr. Smith. Her concern was, she told the Commission, that she *“wouldn’t see it as being practice to take away a comfort from somebody as a punishment”*, whether a child or adult.

- 4.51 Subsequently, on 22nd July, 2008, Ms D made a note of a telephone call from Mrs. X querying why Grace had been changed, in response to which Ms D told her that it was on account of urinary incontinence. Ms D’s note recorded that Mrs. X had told her how a social worker had previously advised her that she should *“punish”* Grace for urinary incontinence, leading Ms D to tell her that that was *“not something encouraged these days.”* In evidence, Ms D said that Mrs. X did not say that she punished Grace, just that a social worker had told her to do that. When she was asked if there was any reference to withdrawing the keys from Grace during that particular conversation, Ms D said that she did not know if that was in relation to that conversation or another conversation, but that it *“certainly arose at one point...”*
- 4.52 Mrs. X did not recall having that conversation or any other conversation with Ms D about punishing Grace for urinary incontinence and said that she would not have said such a thing. Mrs. X said that she had never been told by a social worker to do that. However, as reported upon above at paragraph 4.3, Mrs. X gave inconsistent evidence on this matter.

Findings

- 4.53 The evidence to the Commission established that Grace’s toy keys, which she habitually carried with her, were taken from her by Mrs. X on occasion as a means of punishment or an attempt to discipline her when she was considered to be *“bold”*. Mrs. X also removed these from Grace on other occasions to prevent her from scratching herself with them. The Commission also found that Mrs. X sometimes removed the keys from Grace because she had been incontinent. At times Grace was sent into Day Service Provider A without her keys for the above reasons.

- 4.54 Mrs. X's evidence of what Ms Greaney, the Children's Officer of the South Eastern Health Board, had supposedly advised her with regard to removal of the keys from Grace was unclear and contradictory. Ms Greaney's involvement in Grace's case had ceased in June, 1994, with responsibility being handed over to another social worker, before Grace started to attend Day Service Provider A in September, 1995. The Commission is satisfied that, in the context of the day-to-day care of Grace, it was Mrs. X who decided whether and when Grace's toy keys should be taken from her.
- 4.55 As previously reported, Mrs. X did not have any expertise or training with regard to the care and management of a person with Grace's level of mental disability. She was left to her own devices in how she managed with Grace. Taking the keys from Grace was a feature of her own approach to managing Grace and on the occasions when she did that, she openly told Day Service Provider A why she had done so.
- 4.56 The Commission is satisfied on the basis of the evidence that the misguided intention of Mrs. X in this regard was to prompt a change in what was considered undesirable behaviour on Grace's part, following which the keys would be returned to her. However, it was clear from the evidence to the Commission concerning Grace that the removal of her keys as a means of effecting behavioural change or even by way of discipline was generally an ineffective and misguided strategy given Grace's likely inability to make any connection between so-called "*bad*" or "*bold*" behaviour and removal of the keys. Mrs. X acknowledged in her evidence that it did not work. The action of withholding Grace's keys in an attempt on occasion to bring incontinence under control, appears to have been particularly misguided and there was no evidence that this had or could have had any positive effect.
- 4.57 However, although generally ineffective and misguided, the Commission is satisfied that taking and giving back the keys was a strategy of Mrs. X's that was primarily adopted in the hope of a positive response or behavioural change.
- 4.58 It was clear from the evidence that Grace was upset and frustrated when her toy keys were taken from her. Sometimes they were taken momentarily and sometimes she was sent to her day placement without them. The Commission is satisfied, however, that they were always returned to Grace and, on the evidence of many witnesses to the Commission, she was mostly observed with these in her possession rather than without them. There was no evidence to the Commission of any long-term effects upon Grace as a result of the removal of her keys from time to time. Grace

had the keys when she first came to live with Family X in February, 1989 and had them when she was moved into residential care in July, 2009.

- 4.59 The Commission is not satisfied that the evidence concerning the manner in which Mrs. X treated Grace's keys established emotional abuse of Grace in the circumstances reported above.
- 4.60 The evidence also disclosed that Grace's keys were withheld from her in Day Service Provider A on occasion. The evidence to the Commission demonstrated that this was well intentioned in the staff's interactions with Grace.

5. Aspects of Grace's daily life – at home and in Day Service Provider A

Grace – daily life at home with Family X

- 5.1 The evidence provided to the Commission about how Grace spent her time at home came from Mrs. X, the household members, and observations by other persons, referred to below. Some of Grace's types of activities were mirrored in the evidence about her time in the day placement. While this evidence could not be regarded by the Commission as providing a complete picture of every aspect of her daily life and experiences, it is satisfied on consideration of it that it did provide a reasonably comprehensive insight into and picture of aspects of her life at home.
- 5.2 Grace spent most of her time at home with Mrs. X. There were periods in 1990/1991 during which Mrs. X worked part time for a few hours in the mornings in a neighbour's business and she also did some part-time work in another house in 1996. This is reported in Chapter 3 of this Volume. There was also evidence that Mrs. X's daughter (who died in 1995) minded Grace on occasion. The Commission is satisfied on the totality of the evidence that Grace was attached to Mrs. X, particularly through her dependence on her as her carer. They were company for each other.
- 5.3 The evidence to the Commission was that Grace did not appear to be interested in activities or was unable to sustain an interest in anything in particular. Mrs. X sometimes bluntly expressed her view of the limitations of what Grace could do in her evidence to the Commission. She gave evidence that Grace did not do anything, and would do nothing. Grace was generally assessed by the professionals who dealt with her as having a limited attention span and low concentration. Insofar as Mrs. X is

concerned, it was undeniably the case from the totality of the evidence that she, more than anyone else, was the person who knew Grace over the years that she was in her care and was well placed to comment on this aspect of Grace's life.

- 5.4 There were, however, particular repetitive actions that occupied Grace, at least some of the time. These were not activities that she initiated herself. Grace liked water and liked playing with water. This was reported by a number of witnesses, both with respect to her activities at home and in Day Service Provider A. Mrs. X said that Grace liked playing with water and liked repetitive tasks with it. Mrs. X said that she used to put her standing at the sink, put all the cups into it, and give her a little brush. Grace would then keep going at that for an hour. She would not wash them, but just brush back and forth over the cups. Alpha also remembered Grace's doing the washing up, recalling that one would have to re-wash whatever she had washed.
- 5.5 There was a paddling pool in the garden at some stage when Grace was younger and Mrs. X said that Grace enjoyed it because she had other children with her. This coincided with times when children used to stay on respite in the summer. Grace was reported to like being in the water for baths and showers. This was supported by the evidence from her attendance at Day Service Provider A.
- 5.6 Grace did a lot of walking with Mrs. X on the country roads in the locality. Grace walked at a fast pace and could go for long periods. Mrs. X said that she would "*walk and walk and walk*". Sometimes they walked the dogs. Gamma also said that Grace liked walking and he used to see her and Mrs. X out walking together. He said that Grace was a very brisk walker. Gamma told the Commission that Mrs. X used to visit his father (her brother) down the road. She took Grace for a walk there in the afternoons for a cup of tea and a sandwich. Alpha said that often, when Mrs. X was going for a walk or going to the shop, Grace would walk alongside her and hold her by the hand or by the lower arm. He recalled that Grace and Mrs. X were very close.
- 5.7 Walking was an activity which it was noted that Grace liked in Day Service Provider A too. She was reported to have high energy and to like to move fast. Mr. M recalled that Grace walked three miles a day at home with Mrs. X and that she walked fast and never tired. In June, 1997, in the course of a meeting with Mrs. X designed to assist with planning her activities at Day Service Provider A, Mr. M and Mrs. X discussed the need for vigilance with Grace on the roads, at home, and when attending the day centre. Noting that there were no footpaths in the country and the

windy, twisty roads there, Mr. M recalled that “[Grace] and [Mrs. X] used to walk them every day that the weather was good, weekends. So, she was always in front of [Mrs. X].” He recalled being told that Grace would be “[w]alking [at] breakneck speed, so it was waiting for the sound of cars, but it appears from [Mrs. X] that if she commanded her to stop, she would stop in her tracks kind of thing”.

5.8 Mrs. X also said that Grace went fishing, saying “[Grace] spent lots of time with me doing jigsaws and different things, different games. Go walking with the dogs, go fishing. We used to do loads.” The local voluntary association board member, whose son stayed with Family X, also recalled how he and the other children “used to go fishing with a bamboo stick” in a “little stream.” She recalled that “they had to have their gear and they had to have their wellingtons. It was all just a game but...getting ready for this, getting all the pins and the things ready, that could be the whole morning with [Mr. and Mrs. X].”

5.9 Grace was reported to love going on the swings. This evidence came both from Mrs. X and from Day Service Provider A personnel. Mrs. X said that, when they got swings for Grace, she was “dead happy” with them. Mrs. X said that she had to stand very close to Grace because she would not swing like other children; she would get really excited and go “sky high.” Mrs. X told the Commission that Mr. M said to her that he was terrified that Grace was going to tumble out of them, but that that never happened. This accords with Mr. M’s experience of Grace on the swings, referred to further below. Alpha also told the Commission that Grace had a great fondness for the swings and remembered where they were in the garden. Gamma recalled that Grace went on the swings occasionally. He said that Mrs. X would let her out on them for 20 minutes if it was a nice day.

5.10 When Alpha was a child he would sometimes play with Grace. As reported, when he was younger, he considered her to be his sister. Alpha recalled in evidence that he used to try to teach her basketball, there being a basketball loop in the garden which remained fixed to the side of the house when the Commission inspected the property. Alpha said that teaching Grace to play basketball was difficult, and that he was not successful in it.

5.11 Alpha’s efforts in that regard were noted by Ms Leyshon on her visit on 30th September, 1999 where she recorded that Mrs. X “told me that [Grace] had been with them for 11 years and [Alpha] her grandson [was] v. attached to [Grace]. [Alpha]

joined in the discussion and said that he was teaching [Grace] to play basketball, which she enjoyed. [Alpha was] a very pleasant 11 year old who attends local N. S."

- 5.12 Alpha also recalled Grace's playing ball with Q.Q., saying *"they would try and throw the ball to each other, that kind of, do you know.....It is awkward to describe. They tried to do little things together"*.
- 5.13 Grace's level of activity was sometimes associated with hyperactivity, which was a feature reported in assessments of her over the years.
- 5.14 Both Alpha and Gamma recalled Grace's sitting at the television with Mrs. X. The evidence differed as to whether Grace appeared to like television or whether she could follow what was on it. Mrs. X did not think that Grace liked or was interested in the television or in listening to the radio or music, although she corrected this later in her evidence to say that Grace did like music. This was also observed in Day Service Provider A, particularly that Grace loved to play the drums.
- 5.15 Gamma recalled that Grace watched the television and laughed sometimes, but whether it was at something she had seen he did not know. He saw her as *"happy in her own company"*. As reported above, he also recalled that Grace did not seem to do much, only sit in the chair playing with her keys. He told the Commission that he did not know what Grace's level of understanding was. Alpha told the Commission, *"I suppose she would sit down and play with the keys and watch telly, that was a keen interest. That is all that she ever really done to an extent"*.
- 5.16 Beta's evidence as to what Grace did in the house was limited. However, he recalled that Mrs. X might go walking with her and that he would sometimes see them (sometimes with Alpha and Gamma) inside watching television when he was having his supper. He said that he would only see Grace for three or four minutes at a time. He did not know what they did during the day because he was not there, as he was out at work.
- 5.17 Apart from an attachment to her keys, there was little evidence that Grace was interested in other objects. As reported above, Mrs. X told the Commission that she and Grace spent lots of time doing jigsaws and lots of different games but that Grace was not actually interested in anything. Mrs. X said that she would pull up a chair, put Grace sitting down, and put the pieces of the jigsaw on the table. She would try to get

Grace interested in it, and try to get her to do it, but she said that no matter how she (Mrs. X) tried, Grace would not do it. Having regard to Mrs. X's evidence that Grace was not interested in anything and would do nothing, the Commission considers it very unlikely that these types of game activities with Grace occurred with any regularity.

- 5.18 Mrs. X's evidence was that, at the weekends, they went shopping to a nearby town and that Grace would go with them. She said that they would often go to Chinese or Indian restaurants at the weekends. They went on drives and might go to a nearby town or different places.
- 5.19 Alpha also recalled in evidence that Grace liked going for Chinese and Indian meals. He said that, if he was free at home and they were going out, he would be brought along. It was generally to the nearby town referred to in the preceding paragraph, depending on the day. Alpha said they also did the shopping on these outings. As he grew older, he did not go on these trips as at the weekends he was out with the neighbours, pursuing his interest in horses.
- 5.20 Gamma said that from the year 2000 onwards, being the year Mr. X died, he was more closely involved in the house. He drove Mrs. X where she needed to go. He remembered taking Grace and Mrs. X out several times. He said that they went out on Sundays to the nearby town, maybe to get a Chinese meal. They used to do the shopping afterwards and go home. Gamma started doing those trips after Mr. X fell ill. He also took Mrs. X places with Grace if Mr. X was not available.
- 5.21 Mrs. Q, whose daughter stayed for periods with Family X, as reported upon above, also remembered that Grace regularly went for drives. She said that Family X went to the nearby town to do the shopping. She also said that they went for Chinese food on a Saturday, and that Grace was always in the car with her daughter, Q.Q.
- 5.22 Mrs. X's evidence was that they went out a lot in the summertime. She said that they often went to the pub, approximately five or six miles away, where Grace would have orange and biscuits. Mrs. X said that they used go on picnics, and that they used to take Grace to a nearby seaside town. Members of Mrs. X's own family visited from England over the summer months in order to to spend time with Mrs. X's family in the locality.

- 5.23 Gamma recalled that any time relatives came from England to see Mrs. X, they stayed in a nearby bed and breakfast establishment. He said that they called up during the day to say hello to her. Gamma also said that Mrs. X had friends that came and went from time to time. They called for a cup of tea and a chat. He said Grace did not take any notice of them. Gamma said that Mrs. X had friends all over the place and was very well liked.
- 5.24 The house where Grace lived with Family X was a country house, as described below. They had dogs and cats. Mrs. X said that she never kept birds but that she fed the birds outside. In the course of her evidence on Grace's life at home, Mrs. X said that there were plenty of things to occupy Grace's mind there.

Daily life when attending Day Service Provider A

- 5.25 The evidence to the Commission about Grace's time in Day Service Provider A assisted in providing it with a fuller picture of her life over the years under investigation.
- 5.26 The First Substantive Interim Report has reported upon the background to the establishment and operation of Day Service Provider A. The circumstances in which Grace first started in Day Service Provider A at the age of 16 are reported in the First Substantive Interim Report, and aspects of her life in Day Service Provider A have been reported in both the First and Second Substantive Interim Reports. They are set out below in summarised form, for ease of reference.
- 5.27 An account of Grace's experience over the first seven months of her time in Day Service Provider A was set out in a report that Mr. M prepared for the SEHB in April, 1996. The circumstances of that report have been addressed by the Commission in the First Substantive Interim Report. As the First Substantive Interim Report reports, Mr. M considered that he was being asked for an update in relation to Grace's progress and as to whether the trial period she had been on in Day Service Provider A was going to be extended.
- 5.28 This report provided a picture of the difficulties encountered by Grace in adapting to the significant change in her life associated with her attending a day placement facility at the age of 16 for the first time. Having detailed the problems which had

arisen over Grace's first seven months there, the report summarised her activities when attending the day placement as follows:

"[Grace] loves walking - she would go for miles at an incredible pace. She attends the bowling alley and [a waterpark in a nearby seaside town]. On these occasions she presents no great problem. [Grace] goes to the park to use the swings and slides - these she loves. The multi-sensory room exerts an unbelievable calming effect on her. Also as an aid to calming her down - she loves having her hair brushed...She loves going out in our mini-bus for outings - on these occasions she behaves impeccably."

5.29 Mr. M's report concluded that:

"Overall [Grace] has made remarkable improvements. Gone are the days of containment. We have progressed to the stage of introducing her to outside activities like swimming and bowling. These have been successful to date. She also goes on a daily walk. She now presents no problems to other trainees."

Obviously after confinement at home, she was unaccustomed to dealing with an environment like ours. She now appears more happy and content in herself."

5.30 Mr. M felt that Day Service Provider A introduced Grace to a new world. As he expressed it in evidence, "[s]he was doing things and, okay, I might have loosely referred to it, she was becoming more independent but at least she was being accompanied by someone of her own age out into the wider world to go horse riding or swimming or taking Bus Éireann or whatever else."

5.31 Mr. M said that he remembered Grace as being animated, happy and smiling, emphasising in his evidence that this was his recollection of her in Day Service Provider A. Reflecting on this at the Commission, Mr. M said that he was glad to hear other evidence from Day Service Provider A witnesses describing Grace in such terms. This was because he did not agree with the more negative representations of how she had presented. Mr. M felt that Grace was stimulated by her activities when she attended the day centre and that she exhibited happiness and made sounds to

show that. He said that, while Grace was in her own little world, she was enjoying it there.

- 5.32 Soon after Grace arrived at Day Service Provider A, Mr. M said that they brought her to a park to go on the swings. According to Mr. M, she *“would take your life when she got on the swings, absolutely loved it. But she could swing almost to the top and you would be stood there watching her thinking she is going to come off at the top of the thing.”* CW2 also recalled in her evidence that Grace loved the swings.
- 5.33 Mr. M told the Commission that there was a tricycle in Day Service Provider A and that Grace *“absolutely loved it”*. She was able to do a route around the building cycling at tremendous speeds. Mr. M said that they would have to run after her because she was so fast. She would go up against walls and gates but she enjoyed it so much. CW2 also said that Grace loved the tricycle and that she would go really fast and that they would have to monitor her.
- 5.34 Grace was reported to love going swimming from Day Service Provider A. They had a swimsuit in the centre for her. The evidence was that she tried really hard to participate in the activity. She used to take off her clothes so she could get into the water because she knew all the queues around her and knew exactly where she was going. She used to get into the water and walk up and down laughing to herself. Grace became very animated at swimming and sometimes made sounds. The evidence to the Commission indicated that it was the time when she was most vocal and most engaging and was *“very, very happy to be there.”* It was the single activity that the staff in Day Service Provider A *“absolutely knew would bring out the best out of her.”*
- 5.35 Grace would have her hair brushed and dried afterwards, for which she sat really still and was very calm. There was evidence that she loved to have her hair plaited. That position never changed with respect to Grace over the years. This was described in the evidence as a *“lovely activity”* to do with her. Grace also loved bath time, Mr. M recalling that she loved the bubbles and described her as a *“bubble machine”*. She doused the bath in the bubble mixture and it would rise up resulting in a big clean-up operation afterwards. Mr. M said that Grace was *“at her happiest”* in the bath. CW1 also said that Grace absolutely loved water. The evidence was that she used to get very excited about being in it. She was very calm when they put her in the bath and then washed and brushed her hair.

- 5.36 As reported upon above at paragraphs 5.6 and 5.7, Mr. M recalled that Grace used to go walking at home with Mrs. X.
- 5.37 Mr. M's evidence was that "[Grace] *walked at a tremendous pace... I walk fast but I couldn't keep up with the girl at times*". With regard to crossing roads in town with Grace, he recalled that she would link the staff member. Mr. M felt that Grace knew "*intuitively*" that she needed assistance crossing in those circumstances.
- 5.38 CW5, a programme assistant with Day Service Provider A, recalled Grace as being very active and pleasant. She said that she liked to be on the move and always moved fairly fast paced. She did not like to sit down for long periods of time.
- 5.39 Mr. M also noted that Grace liked horses. They brought her to stables in Waterford and she went horse riding. He said that she took to that. Mr. M observed that Grace "*lived in an area where she would have seen horses every minute of the day*", including on her daily walks at home. Referring to information given by Mrs. X, Mr. M told the Commission that "[w]e had heard she liked stopping obviously to look at horses".
- 5.40 Mr. M also said that Grace loved pop music but hated country and western style music. The fact that Grace seemed to enjoy music and to love drumming was also recounted to the Commission by CW6, a programme assistant in the day centre, CW2 and CW7. Grace was encouraged to participate in this activity and she enjoyed it.
- 5.41 As part of the activities in Day Service Provider A, Grace was taken to cafés and sometimes into shops. The fact that Grace loved tea and drank quite a lot of it was recounted in evidence by Day Service Provider A staff and by Mrs. X.
- 5.42 In line with his view that service users should have as much interaction and as many experiences in the community as possible, Mr. M initiated a Day Service Provider A annual holiday. Day Service Provider A rented houses in a *cul-de-sac* and took service users away on holidays for seven days to either Cork, Killarney or Limerick.
- 5.43 On 25th June 1997, Mr. M had a meeting with Mrs. X about Grace's going on the Day Service Provider A annual holiday. He noted that Mrs. X "*was afraid of her going into [a residential] institution*". Referring to this in his evidence, Mr. M said that that was

not just a concern of Mrs. X's but that all the parents were wary of such institutions, which were closing down all over the country. This meeting coincided with the time when that was happening. A lot of parents did not want their children to go to an institution, preferring a community setting. Mr. M said that Day Service Provider A was the first in Waterford county to be a community setting. Mr. M said that he allayed Mrs. X's fears by indicating that Grace was not going to an institution, but to a bungalow in the middle of a housing estate with coming and going and shops and buses, and that there was *"real life... [not] behind walls."* He said that Mrs. X was happy with that. Grace went on the holiday.

5.44 In his evidence, Mr. M painted a vivid picture of the success of this holiday. He said that Grace was not in bed before two in the morning because she had gone to a disco or something of that nature with them. He said that the sleeping patterns of the service users *"didn't mean anything when we got on holidays, but at the same time we were aware of them."*

5.45 Mr. M said that he really wanted to come back from the holiday with Grace knowing that everything had gone well, and his view was that this holiday had to work for her. He said that they were, accordingly, very conscious before she left that they *"couldn't put a foot wrong."* Once they went on the holiday, however, they did not have a concern for her. Mr. M said that Grace *"entered into the life of everything."* She went to all the activities, whether it was the swimming, the circus, the cinema, the bowling, or the disco. Mr. M said that they went out for every meal and that Grace was great. It was *"a successful holiday."*

5.46 Mr. M recalled that Grace had a suitcase with an array of clothes going on the holiday. Whether or not they were old he did not know, he could not remember, but he said that she was dressed appropriately.

5.47 Mrs. X told the Commission that she was not happy before Grace went to Day Service Provider A, but that when she did go, she was happy because Grace was happy. She thought that Day Service Provider A was of benefit to Grace, in that it occupied her mind with the others there. Although Mrs. X said that she found Grace to be no problem as she (Mrs. X) *"hadn't anybody else"*, she also said that Grace was not easy to anybody else because she never stopped jumping and banging. Mrs. X agreed that Day Service Provider A was beneficial on account of the activities in

which Grace was involved. They were activities that Grace liked and she thought that they were helpful to her.

- 5.48 The evidence to the Commission about the different activities in which Grace took part at Day Service Provider A were recounted as activities that she loved, enjoyed, and was excited about doing. Descriptions of Grace as happy, smiling and enjoying herself in Day Service Provider A were quite regular in the evidence of the staff there. Such observations were made by CW6, CW7, CW1 and Mr. M.

Communications between Day Service Provider A and Family X

- 5.49 The communications between Day Service Provider A and Mrs. and Mr. X provided evidence of the types of issues that arose with respect to the care of Grace. They are reported in this Chapter as they provide further context with respect to such matters.
- 5.50 Certain communications between Day Service Provider A and Mrs. X on specific topics have also been reported, where relevant, in other chapters of this Volume.
- 5.51 Mr. M told the Commission that he believed there was a very good working relationship between Day Service Provider A and Mrs. X. Mr. M said that he contacted Mrs. X by telephone if he needed to. He did not remember corresponding with her by letter; however, as referred to below at paragraph 5.60 *et seq.*, there were notes and short letters that passed back and forth through the bus driver on a variety of issues over the years. These related to practical matters such as arranging for spare clothes for Grace. Mr. M recalled that Nurse N and Mrs. X would also have had long discussions.
- 5.52 Mr. M said that Family X could be telephoned at any time. He rang them early in the morning or while Grace was on her way home. Mr. M said that there was never any time when lines of communication ceased. It was apparent from Mr. M's evidence that information about Grace was provided by Mrs. X, as required.
- 5.53 The Commission also heard evidence, however, that the relationship between Mrs. X and staff in Day Service Provider A was sometimes difficult. Ms Leyshon, the SEHB social worker involved in Grace's case, made a note of having been told this by Mr. M during a conversation in February, 1999. This has already been reported in the Second Substantive Interim Report. Ms Leyshon said in evidence that her description

of the relationship as “*difficult*” was possibly supposition on her part. She assumed that it “*was to do with monitoring [Grace’s] behaviour and perhaps challenging [Family X] from time to time in relation to that.*” In his evidence, Mr. M said that he did not believe that “*difficult*” was the right word to use and that he might have been a little loose with his language. He thought that there was a very good working relationship between Day Service Provider A and Mrs. X. Mrs. X was surprised that Mr. M would describe their relationship as “*difficult*” when asked about Ms Leyshon’s note at the Commission.

- 5.54 In her evidence, CW2 said that she found Mrs. X to be difficult in the course of their contacts. She said that she was afraid to say anything to Mrs. X because she found the relationship quite difficult. She told the Commission that she felt that Mrs. X always rang up to complain so “*if we had to tell her stuff I was quite scared ... to tell her stuff*”. CW2 said that anytime she had contact with Mrs. X, Mrs. X was complaining. Giving instances of this, she said that Mrs. X complained if Grace went home in a different set of clothes or if she had soiled herself, been incontinent, or had a different hairstyle. She also complained if Grace had left an article of clothing behind her, if it was a sunny day and they had not put Grace’s jumper back on her, or if they asked to cut Grace’s hair. CW2 agreed that Mrs. X was concerned about anyone seeming to do Grace down. She did not “*recall her ever ringing up to congratulate us or tell us we were doing a good job. I have always felt it quite difficult to deal with people who are difficult, I didn’t like doing it, I know it was part of my job*”.
- 5.55 CW2 noted that they did their best for Grace in Day Service Provider A. She said that Mrs. X did not complain about the care given to Grace in Day Service Provider A and that she was “*quite pleasant*” at times if they were making small talk. However, she said that “*when it came to [Grace] she could be quite aggressive, not aggressive, quite harsh sometimes in her criticism*” of anyone whom she felt had done something like forgetting to send Grace’s jacket back home with her. As regards who had contact with Mrs. X, CW4 said that Mrs. X was usually contacted by either Nurse N or Mr. M. In CW4’s latter period working in Day Service Provider A, CW1 was her supervisor and so it was either CW1 or Mr. M who made contact with Mrs. X.
- 5.56 CW1 said that she never met Mrs. X; however, there was communication in writing between them and she spoke to her on the telephone. CW1 said that Mrs. X was concerned about Grace’s urinary incontinence and wanted to know about it. In response to notes from Mrs. X, CW1 said that to the best of her recollection, she

telephoned her in response. She said that she always found Mrs. X cordial. CW1 never had the sense that Mrs. X was cross because Grace had wet herself or that she was blaming the day centre for that. Rather, CW1 said that Mrs. X was *“adamant that she wanted to get this fixed and sorted.”* CW1 recalled Mrs. X as being *“direct”* as opposed to aggressive.

- 5.57 Mr. M said there was plenty of telephone contact from Mr. X on practical matters to do with Grace. He said that Mr. X would always ask to speak with Mr. M, while Mrs. X would be happy to speak with himself, Nurse N, or other members of staff. He never met Mr. X in person.
- 5.58 Speaking of his telephone conversations with Mr. X, Mr. M said that there were many and varied reasons for them. They could have been about clothes, or Mr. M’s telephoning Family X to enquire where Grace was, what was wrong with her, and to find out when she would be coming in. Mr. X could also have been telephoning to say that Grace had gone to the doctor, that she had had her period and was not feeling well, that she had been barred off the bus, or that she had been banging her head going home on the bus and was being kept at home for a few days because she was sore. He said that most of the communication between them would have been as a result of Mr. X’s telephoning.
- 5.59 Mr. M said that Mr. X always rang to *“establish facts”* and recalled them as being *“abrupt”* calls, saying that they were *“never friendly”*. Mr. M said that he found Mr. X *“difficult”* to talk to, recalling that there was *“no idle chat”* and that *“we wouldn’t have spoken about anything other than what we were supposed to be talking about.”* Mr. M said that Mr. X would tell him about incidents, such as something that had happened on the bus, and ask if Mr. M knew what had happened. Mr. M said that it was *“stuff that I couldn’t really answer because I couldn’t disclose the name of any of our [service users] on the bus and put them in the frame.”* Mr. M said that he used to tell Mr. X that one or other of the bus drivers would have told him about what might have happened and he supposed that he must have told Mr. X that they were not able to have had *“any control over that”* as they were not on the bus.

Correspondence between Mrs. X and Day Service Provider A

- 5.60 The topics addressed in notes and letters from Mrs. X to Day Service Provider A, (referred to in this and other chapters) related to ordinary day-to-day concerns that

arose from time to time in the context of Grace's attendance at the day centre. Issues to do with her incontinence and clothes were a regular topic of communications between Mrs. X and Day Service Provider A, as further set out by way of example in those below.

- 5.61 A note from Mrs. X to Nurse N in December, 1996 stated: *"Hope you had a good party. Am returning the clothes you so kindly lent [Grace] – what happened? Thanks...PS [Grace] is in great form."* Nurse N replied as follows: *[Grace] got her period that day...that's why we changed her clothes. No problem. She is in great form. Regards, [Nurse N]"*.
- 5.62 A letter in January, 1997 from Mrs. X to Nurse N stated that: *"[Grace] is a lot better so [I] am sending her back to the workshop. One problem still remains- she has cold sores on her lips but we are treating them. She has been very good all this week, no wetting at all, so lets hope this will continue. I think she has missed the workshop she seems to be happy there. Thanks for everything. [signed, Mrs. X]"*
- 5.63 An undated note from Mrs. X to Nurse N stated: *"Dear [Nurse N], Let me begin by wishing all you a very happy new year. Thank you for the Xmas present for [Grace]. It is most appreciated. Thank you for her clothes which I received on Friday. Pity she had an 'accident' it's just one of those things. [Grace] is very good & very happy these days. Thanks for everything. [signed, Mrs. X]"*.
- 5.64 A note from Mrs. X to Nurse N dated 22nd June, 1998 stated: *"Dear [Nurse N], [Grace] has had a great holiday, she has been very good not a single case of wetting, in fact she has started to go to the toilet without being told. Let's hope there will be no more 'accidents' at the workshop. Sincerely, [signed, Mrs. X]"*.
- 5.65 An undated note from Mrs. X to Nurse N stated: *"Dear [Nurse N], Just a short note to let you know [Grace] is fine again. Her mouth problem has cleared up. There have been no problems like wetting at all so lets hope it will continue. Sincerely, [signed, Mrs. X]"*.
- 5.66 A note from Mrs. X to Nurse N dated 25th September, 1998 stated: *"Dear [Nurse N], [Grace] was dry when she got home. From day (Friday) I will send her in a nappy. When she arrives to you, you would be good enough to put her in knickers. I am returning clothes and knickers etc which you loaned her. Thanks. [signed, Mrs. X]"*.

- 5.67 A note from Mrs. X to CW1 dated 23rd November, 1998 stated: *"Dear [CW1] Just to let you know that I will be sending in a cake and a few goodies for [Grace's] birthday party to-morrow Tuesday. This last week [Grace] has been so happy – no wetting in fact I am sending her in in knickers – no nappy. Thanks for all you have done. [signed, Mrs. X]"*.
- 5.68 A note from Mrs. X to CW1 in February, 1999 stating *"Dear [CW1], Thank you for the way you looked after [Grace] this past month. Apart from today she has been excellent, let's hope this was a once off. Thank you. [signed, Mrs. X]"*.
- 5.69 An undated note from Mrs. X to Mr. M stated: *"Dear [Mr. M], [Grace] is in great form again. Hope she'll be happy at the workshop, she hasn't been eating too good. However any problems let me know and I'll keep her at home, thanking you [Mr. M] and everyone at the workshop for all their help regarding [Grace]. Happy new year to all. [signed, Mrs. X]"*.
- 5.70 An undated note from Mrs. X to CW1 stated: *"Dear [CW1], What a pity [Grace] spoilt her self but as you say two weeks is a good start – lets hope it continues – Thanks. I phoned [Mr. H] the bus driver and he tells me there is a lad on the bus who needs watching – he gets at the kids and his name is [name of individual]. They are going to keep a close watch on him. Thanks a lot. [signed, Mrs. X] PS Have you [Grace's] ...yellow jumper with the word 'Honey' on it"*.
- 5.71 An undated note from Mrs. X to CW2 stated: *"Dear [CW2], I am sending in 5 pairs of knickers for [Grace's] use in case of accidents. Hope she will not need to use them. Also [I] am sending in two pairs of long pants, for use if needed. Returning other clothes. Thank you for everything. [signed, Mrs. X]"*.
- 5.72 An undated note from Mrs. X to CW1 stated: *"Dear [CW1], Unfortunately [Grace] is wetting herself again. It appears there is someone on the bus who is 'getting at her'. Thanks for the good job you have done. By the way, [redacted] is the lad's name. Thanks. [signed, Mrs. X] P.S. The boy has been reprimanded yesterday so let's hope that's an end to it."*
- 5.73 An undated note from Mrs. X to Ms Nurse N stated: *"Dear [Nurse N], [Grace] has again wet herself. I think it better we keep her at home as we do not have this*

problem with her when she stays. I would be glad to know what you think. Thanks for all you have done for her. [signed, Mrs. X]”.

- 5.74 An undated note from Mrs. X to Nurse N stated: *“Dear [Nurse N], Was very sad to see [Grace] had an ‘accident’, she has been so good. I am sending you some spare clothes for the future. Has she been playing up. Thanks a lot. [signed, Mrs. X]”.*
- 5.75 An undated note from Mrs. X to Nurse N stated: *“Dear [Nurse N], When [Grace] arrived home she was soaking. I am taking her to the doctors to find out if there is anything wrong with her. Additionally she wet at the workshop. Over the weekend there was no problem. [Grace] seems to really enjoy the workshop. So it seems to be something organically wrong. Will phone the result of the visit. Thanks [Nurse N] for all you do. [signed, Mrs. X]”.*
- 5.76 An undated note from Mrs. X to Mr. M stated: *“Dear [Mr. M], Last week I arranged with [Nurse N] that I would send [Grace] in a nappy for her to be changed into knickers on arrival (knickers supplied). Imagine my disappointment finding her in a nappy on arrival home again. To keep her in nappies is a step backwards. Thanks [signed, Mrs. X]”.*
- 5.77 An undated note from Mr. and Mrs. X to Mr. M stated: *“Dear [Mr. M], Just a few lines to let you know [Grace] is fine again. She has had a course of antibiotics and they have done the trick. In the wetting department – excellent, not a single case. Let’s hope it continues. Hope all goes well. [signed, Mr. and Mrs. X]”.*
- 5.78 These notes were again limited snapshots of ordinary issues addressed in connection with Grace’s attendance at her day centre. They did, however, convey a degree of concern, on the occasions that they were written, for matters likely to affect Grace adversely, rather than evidencing disregard for her well-being.

6. Findings

- 6.1 The evidence to the Commission, particularly relevant to the question as to whether it was established that Grace had been intentionally or negligently subjected to emotional abuse (as a standalone concern) has been considered in this Chapter. The wide breadth of circumstances that may evidence emotional abuse is evident from various guidelines and policies concerning children (some of which post-date the

time period when Grace was a child) and vulnerable adults, referred to at Section 2 above, which have been set out for illustrative purposes. The guidelines emphasise the difficulty in evaluating emotional abuse in any given case.

- 6.2 With respect to a child, the 2017 version of *“Children First”*, referred to at paragraph 2.8 above, describes emotional abuse as *“the systematic emotional or psychological ill-treatment of a child as part of the overall relationship between a caregiver and a child”* and that *“Abuse occurs when a child’s basic need for attention, affection, approval, consistency and security are not met, due to incapacity or indifference from their parent or caregiver.”* Those guidelines point out that abuse can also occur when adults responsible for taking care of children are unaware of or unable to meet their children’s emotional and developmental needs.
- 6.3 With respect to vulnerable adults, the South Eastern Health Board’s 1997 draft policy and procedures with respect to vulnerable adults stated that: *“The person should have a sense of acceptance and approval by others and should not be subjected to an unreasonable level of criticism. The person should feel a sense of security within the home environment.”*
- 6.4 As stated at paragraph 2.3 above, the policy and procedure document for the protection of vulnerable adults prepared in 2005 by the HSE for the South East area described emotional abuse as: *“Controlling through fear by shouting, shaming or humiliating deliberately misinterpreting a person’s communication. This is the threat of violence or isolation, including name-calling and other forms of assault. It includes denial of basic rights, inclusive of choice, opinion or privacy, malicious teasing, taunting, unjustifiably ignoring or rejecting.”*
- 6.5 The Commission has considered the detailed evidence, including that drawn from the observations of witnesses, as reported in this Chapter, that related to interactions with Grace and to the manner of communication with her; the nature of her relationship with Family X and, in particular, with Mrs. X as her carer; and aspects of her life at home and in her day placement. As noted at the outset, the evidence to the Commission, although extensive, could not be expected to present a complete and comprehensive picture of all aspects of Grace’s daily life over a period of 20 years. However, the Commission is not satisfied that the extensive evidence provided was such as to establish or support a finding that there had been systematic emotional or psychological ill-treatment of Grace as a child or a vulnerable adult falling within the

broad ambit of the examples of emotional abuse contained in the guidelines and policies set out in Section 2 above, or otherwise.

- 6.6 Given Grace's attachment to her toy keys as a comfort, the Commission had particular regard to how their importance for Grace was appreciated and to the circumstances in which these were withheld from her from time to time. The facts established about this aspect of Grace's care are reported in Section 4 above. The Commission is not satisfied that the removal of Grace's keys on the occasions when this occurred and in the circumstances reported was such as to constitute systematic emotional abuse or ill-treatment of her.
- 6.7 It should be observed that the health board's fundamental responsibility to source and arrange for Grace's attendance at an educational facility suitable for her needs during her childhood after she came into the care of the SEHB until a place was secured for her at Day Service Provider A in 1995 has been reported in Chapter 5 of the First Substantive Interim Report and is further considered in Chapter 3 of this Volume, where the issue of absences from Grace's day placement is also reported. The Commission is satisfied that this aspect of Grace's care is appropriately considered under the heading of neglect.

END

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Volume 4 – An Garda Síochána

1. Terms of Reference

- 1.1 Part IV. e) of the Commission's Terms of Reference requires it to establish, in the context of the monitoring and review of the care provided by Family X to Grace, facts relating to:

“the extent to which relevant information pertaining to Grace was shared among the various professionals and other relevant employees of public authorities with a duty of care to ensure her care and protection, including members of An Garda Síochána in contact with her from 1989 to 2009.”

- 1.2 This Volume focuses on the involvement of An Garda Síochána in relation to two incidents involving Grace that were reported to them on 20th August, 2008 and 27th March, 2009, respectively, and the extent to which relevant information pertaining to Grace was shared with An Garda Síochána and also by and within An Garda Síochána with respect to these incidents.

2. Introduction to the matters under investigation

- 2.1 The first incident, reported to An Garda Síochána on 20th August, 2008, related to bruising around Grace's right eye noticed by staff at her day care centre at Day Service Provider A, Waterford. Staff telephoned Mr. Iain Smith, Social Work Team Leader for Vulnerable Adults in Waterford Community Care Area, who considered the report was suggestive of non-accidental injury. Mr. Smith then telephoned Waterford Garda Station asking if, on behalf of the HSE, he could bring Grace for medical examination and to see if there was an adult protection service in Waterford Garda Station to look into the matter.
- 2.2 The second incident, reported to An Garda Síochána on 27th March, 2009, related to bruising on Grace's chest and thigh and scratches on her body which were noticed by staff at Day Service Provider A. Staff telephoned Mr. Smith and he attended the centre. The Emergency Department of Waterford Regional Hospital was contacted by Mr. Smith by telephone. They advised that a referral

to the Sexual Assault Treatment Unit (the “SATU”) at Waterford Regional Hospital might be appropriate given the location of the marks as reported to them. They advised that the Gardaí should be notified. Mr. Smith telephoned Waterford Garda Station. Gardaí attended Day Service Provider A and Grace was ultimately brought to Waterford Regional Hospital where she had a forensic medical examination at the SATU.

- 2.3 The background to the reason why Day Service Provider A staff were in communication with Mr. Smith with respect to Grace during this time is more fully examined by the Commission and reported upon in Volume 1. It is important to observe at the outset that the matters reported upon with respect to the above term of reference in this Volume do not include the Commission’s findings of fact with respect to whether or not the above incidents did, in fact, evidence an assault of Grace on either of those occasions. The findings concerning the Commission’s investigations of these incidents will be reported in Volume 3 (the “Care Volume”).
- 2.4 Decisions with respect to the management of Grace’s case were being made within the HSE over the period examined in this Volume. The Commission’s investigation into the management of Grace’s case by the HSE over this period is reported upon in Volume 1. It is important to note that decisions taken by the HSE in Grace’s case were not dependent upon the carrying out of or the outcome of any investigation by An Garda Síochána over that time.
- 2.5 Reference will be made throughout this Volume to the statutory provider of health services. The Health Service Executive will sometimes be referred to as “the HSE”. Reference will also be made to the South Eastern Health Board, the predecessor of the HSE in respect of the functional area of certain counties in the South East of Ireland. It will generally be referred to as “the SEHB.”
- 2.6 Reference will be made to “Day Service Provider A” throughout this Volume. Day Service Provider A was a service established in 1987 and managed by a local voluntary association in Waterford, catering for adults with intellectual disability in Waterford. It had formal links with and was funded by the HSE.

3. Methodology

- 3.1 The methodology employed in the investigations underlying this Volume is reported upon in Chapter 2 (Methodology) of the Commission's First Substantive Interim Report.¹
- 3.2 Certain persons and places are anonymised in this Volume where this is required to protect the identity of Grace. The convention of referring to Family X as the family with which Grace resided is continued. The village in which Grace resided in foster care is referred to in this Volume as "the Village" and its Garda Station is referred to as "the Village Garda Station". The Sergeant at the Village Garda Station is referred to as "Sergeant Epsilon". Three other persons living in or within the curtilage of Family X's residence are referred to as Alpha (the grandson of Mrs. X), Beta (who was not related to Mrs. X but resided in an apartment at the rear of the Family X home) and Gamma (the nephew of Mrs. X, who lived within the curtilage of the Family X home).

4. Witnesses

- 4.1 The Commission heard from over 30 Garda witnesses in respect of the matters set out in this Volume. The ranks attributed to those Gardaí in this Volume are the ranks they held at the time. Many of them have been promoted and/or have retired since then and no longer hold the rank they held at the relevant time. Other witnesses that the Commission heard from fell into three main categories, namely: (a) HSE personnel; (b) Day Service Provider A / local voluntary association personnel; and (c) personnel attached to the SATU at Waterford Regional Hospital.
- 4.2 As part of its inquiry, the Commission considered the roles, organisational arrangements and responsibilities of An Garda Síochána and of various members and officers. It also considered the operation of particular systems in place at the time to the extent that they were designed to facilitate the sharing of relevant information among members of An Garda Síochána. Some of the

¹ Published by the Department of Health on 1st October, 2021 - <https://www.gov.ie/en/publication/856fd-farrelly-commission-of-investigation-substantive-interim-reports/>

organisation and systems arrangements considered by the Commission included:

- oversight and supervision of junior members of An Garda Síochána;
- transfer of reported incidents from one Garda District to another for investigation;
- adherence to the Crime Counting Rules;
- use of the PULSE system;
- exchange of information at daily / weekly Accountability Meetings;
- adherence to the Garda Crime Investigation Techniques Manual;
- tracking of forensic samples taken for analysis; and
- issues involving SATU reports.

5. Overview of relevant Garda management and organisational arrangements

An Garda Síochána

5.1 An Garda Síochána has its headquarters in the Phoenix Park, Dublin. Geographically, for policing purposes, the State is divided into a number of regions, each region headed by a Regional Commissioner. The regions are in turn divided into Divisions, each headed by a Chief Superintendent. The Divisions are further divided into Districts and Sub-Districts under the control of a Superintendent.

5.2 A written Garda Code was in operation at the times of interest to this investigation.² This provided the standard operating processes and procedures

² Garda Code 5th edition of Volume 1, issued August, 2005 and in operation at the time of the events under consideration by the Commission.

for members of An Garda Síochána and was to be viewed as a mandatory guide for all work activities.

Oversight and supervision within An Garda Síochána

Sergeants

5.3 Under the Garda Code, sergeants are the first line supervisors and operational team leaders. It is their duty to ensure all front-line Garda services are delivered and that tasks are carried out in a timely, efficient and effective manner.

5.4 The Sergeant's Supervisory and Leadership Responsibilities included the following:

- *Ensure that all staff members possess the necessary knowledge, skill and competencies to perform their duties in an efficient and effective manner;*
- *Provide coaching, guidance and support for staff in the context of their duties and responsibilities. Student and Probationer Gardaí and junior staff members shall be given special consideration, support, assessment and direction;*
- *Access the PULSE systems, review incidents and brief members on relevant incidents, matters requiring attention and current policing priorities;*
- *Review the performance of staff members with a view to ensuring that:*
 - *Duties are fully and professionally attended to;*
 - *Excellent performance is recognised and rewarded;*
- *Actively supervise and lead local policing operations and activities;*
- *Review and quality assure official files and reports by staff. Sergeants will ensure that the files contain all the necessary proofs and supporting*

documentation and exhibits before such files are forwarded. This is a critical and essential supervisory duty.

- 5.5 In addition to the supervisory and leadership responsibilities of a sergeant outlined above, the Garda Code provided for additional duties and responsibilities for a Sergeant-in-Charge of a Sub-District.³ In particular, it provided that such a sergeant had responsibility for the overall policing of the Sub-District, particularly in relation to crime prevention and detection, public order / public safety, road safety / traffic management, criminal intelligence and victim support, while delivering a service that was courteous, respectful, helpful and professional.

Inspectors

- 5.6 The role of the Inspector was to manage and coordinate the operational delivery of policing services across teams and units and to provide a quality assurance function at the level of operations, investigation and activity evaluation. Inspectors came under the control of their Chief Superintendent unless otherwise assigned.

Superintendents

- 5.7 The Superintendent, as District Officer, had overall responsibility for policing in his/her District. The Garda Code provided that the purpose of the Superintendent was to manage and lead the development, delivery and evaluation of comprehensive policing services within his/her assigned Garda District, thereby ensuring that accountable, quality assured, continuously improving professional services were provided for customers and citizens.

The Crime Counting Rules

Recording and counting

- 5.8 The Garda Code provided the criteria to be met in order to categorise an incident as a criminal offence on the PULSE database and incident reporting system (the acronym PULSE stands for Police Using Leading Systems

³ Garda Code - Chapter 21.

Effectively). It provided that “a criminal offence is recorded when there is a reasonable probability that a criminal offence took place and there is no credible evidence to the contrary.” It went on to provide that a criminal offence should be recorded and counted against the Garda Sub-District in which the particular offence was committed. Where the place of commission could not be determined, the offence was to be recorded against the Garda Sub-District in which it was reported. If a criminal offence had been recorded and a Garda investigation subsequently determined that a criminal offence did not take place, the criminal offence was to be marked as invalid on PULSE.

Responsibility for ensuring compliance with Crime Counting Rules

- 5.9 District Officers were responsible for ensuring compliance with the crime counting rules in their District. All information recorded on PULSE was to comply with the Crime Counting Rules and supervisors (sergeants) were required to pay particular attention to compliance when carrying out PULSE supervisory reviews.

The PULSE system

- 5.10 The PULSE computer system was first introduced in An Garda Síochána in 1999. It was, and still is, An Garda Síochána’s channel for the recording of reported crime, as well as a range of other incidents, including the detection of crime incidents.
- 5.11 The Commission has adopted and repeated relevant parts of the report of the Commission of Investigation into Certain Matters Relative to the Cavan/Monaghan Division of An Garda Síochána (the “O’Higgins Commission Report”) dealing with the description and operation of the PULSE system.⁴ These passages are of assistance to the Commission in its understanding of the system, and in the gathering of evidence and its analysis. The Commission wishes to acknowledge that assistance.
- 5.12 The central purpose of PULSE is to collect information in an electronic format. There are some obvious benefits to such a system, such as a reduction of

⁴ This report was presented to the Minister for Justice in April, 2016.

Garda administration and paperwork, improved support for front-line policing and investigations, improvements in Garda planning and management activities, and easier retrieval of information. During the time that concerns the Commission's inquiries, the PULSE system was not intended to replace the investigative process associated with incidents but was intended to assist Gardaí in the conduct of investigations by having speedy access to data from a central location.

- 5.13 In establishing the facts with respect to the sharing and transmission of information internally within An Garda Síochána regarding the reports about Grace, the Commission examined the manner in which each incident, once notified, was recorded and tracked.

Obligation to record all Incidents

- 5.14 By virtue of the PULSE user manual, a member of An Garda Síochána was obliged to record all incidents coming to his or her notice in a complete and timely manner. An incident was defined as *“any occurrence which requires follow up activity by a Garda once he/she becomes aware of it.”* This obligation was fulfilled when the incident had been created on PULSE by or on behalf of the reporting member. The reporting member was defined as *“the Member who attends the scene, or if the scene was not visited, the member who takes full particulars from the complainant.”* The “reporting member” was distinct from the “investigating member”, the latter being the one assigned to investigate or responsible for investigating the incident.

The Garda Information Services Centre (GISC)

- 5.15 In the early years of the PULSE system, Garda members had to return to, or attend at, a station with a computer terminal which was connected to PULSE in order to operate the system. This diminished the efficiency of the PULSE system. Accordingly the Garda Information Service Centre (GISC) was introduced into An Garda Síochána in 2006. This system enabled members of An Garda Síochána to input incidents without having to return to a Garda station.

- 5.16 Using dedicated mobile telephones, Gardaí contacted GISC where civilian staff entered incident details on PULSE and quality reviewed the information recorded.⁵ The Garda member provided all of the relevant details of the incident, including its categorisation, location and a narrative account of what occurred, to the civilian operator in GISC. The operator then uploaded that information onto the PULSE system thereby creating a PULSE incident. In addition to helping with data entry, members of GISC also reviewed incidents to ensure they met the required quality standards. GISC staff (called incident creation representatives) used an “*Incident Creation Guideline Document*” for this purpose. However, the responsibility for crime classification itself remained with the Garda providing the information.
- 5.17 An indispensable aspect of PULSE is the review functionality which was part of the system since 1999. Review requirements were developed over the years. Examination of PULSE entries by a supervisor has now been recognised as integral to the proper working of the system. When the direct entry of incidents onto PULSE by Garda members was established across the organisation, the review function was done electronically. It remained a task for a supervisor only, usually a sergeant, although another member of Garda rank could be nominated by a superintendent if necessary.
- 5.18 In 2006, following the establishment of GISC, the review function was divided into two parts. GISC staff were responsible for reviewing incidents to ensure they met the required quality standards, but the responsibility for ensuring the correct crime classification remained the responsibility of the reporting Garda. GISC has a quality review function but the sergeant/supervisor role is more focused on the operation or the investigation. GISC was responsible for ensuring the incidents were recorded accurately and fully in accordance with the Crime Counting Rules and for highlighting any missing information. The supervisor’s role included monitoring information about the incident, ensuring the investigation was conducted properly, and checking the narrative for updates. Another important duty of the supervisor was to ensure an effective review of the classification of the crime. Garda HQ directives were circulated over the years dealing with these matters.

⁵ Garda Annual Report 2006.

Location of incident entered on PULSE

- 5.19 The location of the incident entered on PULSE determines the Garda District on whose PULSE system the incident would appear. For example, if an incident is reported to An Garda Síochána in Waterford as having occurred in Clonmel, then the appropriate location for the incident for entry on PULSE would be “Clonmel”. That incident would then appear on Clonmel’s PULSE system as having occurred in that District. It would not appear on Waterford’s system.

Categorisation of incidents

- 5.20 The PULSE user manual listed 27 categories of incidents ranging from the non-crime categorisation of “*Attention and Complaints*” to crime categories such as “*Assaults*” and “*Sexual Offences*”. Within each category there was a number of incident types from which a member could choose. For example, under the category “*Assaults*”, a range of incident types was listed, including, “*Assault Minor*” and “*Assault Causing Harm*”. Again, by way of example, under the category “*Sexual Assaults*”, “*Sexual Assault*” and “*Sexual Offence involving Mentally Impaired Person*” were included. For the purposes of the Commission’s inquiries, the ‘*Attention and Complaints*’ category is of importance and will be returned to in greater detail later in this Volume.
- 5.21 In the documents reviewed by the Commission and in the evidence received by it, the words “*categorisation of incidents*” and “*classification of incidents*” were used interchangeably, but have the same meaning.

PULSE supervisory review by sergeants

- 5.22 As set out in the PULSE user manual and the Garda Code, the supervisor for the purpose of reviewing PULSE incidents was a sergeant, or in the absence of a sergeant, a member designated by the District Officer. Sergeants were to ensure incidents were reviewed as soon as practicable after the incident had been recorded.

Incident Overdue Review Reports

- 5.23 The PULSE system provided for an “*Incident Overdue Review Report*” which was automatically generated and emailed to the District Office on a weekly basis. The purpose of this report was to inform the District Officer of incidents relevant to his/her District, which did not have a status of ‘*Reviewed*’, three months after creation.
- 5.24 The District Officer or a nominee was to examine the report on a weekly basis, ensure that incidents that appeared on the report were promptly reviewed, and report monthly to his/her Divisional Officer on the position regarding the Incident Overdue Review. District Officers were required to ensure that all incidents were marked “*Reviewed*” and were compliant with data capture policy and procedure.

Daily/weekly accountability meetings

- 5.25 Introduced in 2006, the “*Accountability Framework*” comprised a series of daily/weekly meetings which were designed to formalise accountability for all sections within An Garda Síochána. The framework included District accountability, Divisional/sectional accountability, regional/branch accountability, and strategic accountability. For current purposes, the Commission is concerned with District accountability.
- 5.26 Daily meetings were to be held each morning by the District Officer or by the Inspector acting in his/her absence. According to the “*Accountability Framework*”, the business of the daily meeting was “*to enquire into incidents for the previous 24 hours, to give appropriate direction in the management of same and to discuss the availability and management of resources and tasking for the next 24 hours.*” Inspectors, sergeants and members of Garda rank were to attend as required. Minutes were to be taken, stored and made available at the public office in each Garda station for all District personnel. No daily meeting was required on the day the weekly meeting was held.
- 5.27 Weekly meetings were to be held on a set day, where possible, by the District Officer or by the Inspector acting in his / her absence. The meeting was to be attended by supervisors and members of Garda rank who are on duty and

required by the District Officer. As well as conducting the business of the daily meeting, referred to above, items on the agenda (which is not exhaustive) were to include a broader range of issues, for example goals/objectives of the District policing plan; human resource management; financial resource management; and physical resource management. As with the daily meetings, minutes of the weekly meeting were to be taken and made available at the public office in each Garda station for all District personnel.

Transfer of a reported incident from one Garda District to another

- 5.28 There are no specific provisions in the Garda Code dealing with the transfer of a reported incident from one Garda District to another. However, Chapter 47 of the Garda Code, under the heading “*Intercommunications*” provided that, as a general rule, communications between stations in different Districts should pass through the District Office. Members-in-charge of stations were, however, permitted to communicate with one another directly by telephone or otherwise in respect of urgent matters such as absconding offenders or any matter of “*a routine nature*”. This matter is returned to in greater detail later in this Volume.

Crime Investigation Techniques Manual

- 5.29 Described in its preface as a comprehensive reference publication providing guidance and instruction to all officers and members of An Garda Síochána when involved in complex and challenging criminal investigations, the Crime Investigation Techniques Manual⁶ (‘the Manual’) was issued to all officers and members. Specific aspects of the Manual relevant to the matters under consideration in this Volume are set out below.

Witnesses

- 5.30 Chapter 3 of the Manual provided, among other things, that it was of “*supreme importance*” that all potential witnesses be located as speedily as possible and information in their possession concerning the crime obtained from them. It stated that when a crime was committed (as *per* the Crime Counting Rules) a clear obligation rested on the investigating members to take positive steps to

⁶ Crime Investigation Techniques Manual (3rd ed., 2007).

locate and interview thoroughly all possible witnesses. A formal interview was to be done as soon as possible after a crime in order to obtain information when it was still fresh in the witness's mind.

Examination and analysis of evidence

5.31 Items of potential evidence requiring examination or analysis were to be conveyed, without undue delay, to the Technical Bureau or Forensic Science Laboratory,⁷ as the case may be. A Form C.56 (which was to include a list of all items/substances being submitted) was required to be completed in each case, regardless of the type of technical or forensic analysis required. In sexual assault, rape crimes and other serious cases, Form C.56 was to be accompanied by a report outlining the circumstances of the incident and what forensic examination was required.

Possession of clothing and medical examination

5.32 Chapter 11.4 of the Manual provided, among other things, that, *“before making arrangements for a [medical] examination, the investigator should determine if the clothes being worn at the time of the complaint were the same ones as those worn on the occasion of the attack. If not, the relevant clothing should be secured from the complainant for laboratory examination.”*

Role of the Forensic Science Laboratory

5.33 The role of the Forensic Science Laboratory in sexual assault cases is to examine material for evidence of the alleged sexual activity.

Tracking of forensic samples taken for analysis

Property and Exhibits Management System (PEMS)

5.34 The Property and Exhibits Management System (“PEMS”) is a computer tracked property management system. Two significant aspects of PEMS are as

⁷ Originally known as the Forensic Science Laboratory, Forensic Science Ireland (‘FSI’) was established in 1975 to provide a scientific service to the Criminal Justice System by analysing samples submitted from crime scenes and providing expert evidence in criminal trials. In this report, the agency will be referred to using its earlier title, Forensic Science Laboratory, being the name commonly in use at the times relevant to the matters under investigation.

follows: first, it provides for a computerised Property Exhibit Tracking System (“PETS”) to track all property moving in and out of the relevant Divisional property store; and, secondly, it provides for periodic reminders, known as PETS Follow Up Report Reminders, to be sent to the member recorded on the system as being responsible for the property. As PEMS is a Divisional property store the PETS Follow Up Report Reminders are sent out from the Divisional Office. They are addressed to the District Office of the member recorded on the system as being responsible for the property. The District Office then has the reminder sent to the relevant member in their District. The member sends a reply, *via* his/her District Office, with an instruction to either retain, destroy, or return the property to the owner.

Issuing of Sexual Assault and Treatment Unit reports to An Garda Síochána

- 5.35 Insofar as the procedures in the SATU for the provision of medical reports to An Garda Síochána are concerned, in respect of an examination that was carried out prior to July, 2010, a report was sent to the investigating Garda upon request from An Garda Síochána. Any report in respect of an examination carried out after July, 2010 is sent automatically to An Garda Síochána without a specific request.

6. Contact between the HSE and An Garda Síochána in 2007 concerning Grace

- 6.1 In September, 2007, approximately a year before the incident reported to An Garda Síochána on 20th August, 2008, Mr. Iain Smith, Social Work Team Leader for Vulnerable Adults with the HSE, contacted Sergeant Epsilon, in the Village Garda Station, to make some enquiries in relation to Grace whose case had come to his attention in 2007 in the circumstances reported upon in Volume 1.
- 6.2 By way of background, at that time Sergeant Epsilon was the local Garda Sergeant in the village in the South East where Grace lived with Mrs. X. The Village Garda Station was manned by Sergeant Epsilon and by one other Garda who also worked regularly in a larger Garda station in a nearby town. The area was, in 2007, a Sub-District of Clonmel in the Tipperary Division. In

2009, following a Divisional boundary change, the Village Garda Station was transferred into the Kilkenny/Carlow Garda Division.

- 6.3 The Village Garda Station was a small one room station with very limited facilities. It had no patrol car until Sergeant Epsilon was assigned a second hand patrol car in the early 2000s. The Commission heard that there was, generally, not much crime in the area. While Sergeant Epsilon was not a community sergeant, the Commission is satisfied that there was a strong element of community policing in his day-to-day work.
- 6.4 There was no contradiction before the Commission of Sergeant Epsilon's evidence that, although he was an experienced member of An Garda Síochána with thirty four years service, he had never been in the detective or crime branch and had never received any updated or specialist training in the area of investigation of alleged sexual assault.
- 6.5 On 18th September, 2007, Mr. Smith made contact by telephone with Sergeant Epsilon. Mr. Smith told the Commission that the purpose of this call was to gather further background information in relation to an assessment he was carrying out with respect to Grace at this time.
- 6.6 There was no complaint conveyed by Mr. Smith to Sergeant Epsilon regarding Grace during this telephone call. This was the first contact between Mr. Smith and Sergeant Epsilon.
- 6.7 Mr. Smith made a note of the call in the following terms:

"[Grace]

Tuesday, 18th September 2007.

T/c to Sergeant [Epsilon], [the Village] Gardaí.

[Sergeant Epsilon] rang me back after talking to [another Garda].

[Sergeant Epsilon] said that he knew of [Family X]. He knew [Alpha] from around the town.

He said that they thought that [Mrs. X] had a child up at the house who was picked up for school each day in a minibus driven by [Bus Driver].

I explained that this was [Grace].

I asked who else was up at the house and [Sergeant Epsilon] said that there was a [Beta] ... who was somehow related to [Mrs. X]. [Sergeant Epsilon] said that he lived in the little building out the back of the house. I said that I thought this was [Gamma].

[Sergeant Epsilon] said that [Gamma] had a place in town. He drove [Mrs. X] around.

[Mr. Beta] worked in [a local business].

[Sergeant Epsilon] spoke highly of [Beta] [mentioning a community context in which he knew him].

I told [Sergeant Epsilon] I had enquired of the 1996 notification. He had not heard of any concerns in relation to [Family X].

We briefly discussed [Grace's] situation and I outlined why she was so vulnerable and in a legal limbo.

Iain Smith".

- 6.8 Sergeant Epsilon did not particularly remember this telephone call by the time he gave evidence to the Commission and did not take issue with the content of Mr. Smith's note. In recalling his knowledge of Family X at the time and the information he had received from the other Garda before returning Mr. Smith's call, Sergeant Epsilon said that he knew there was a lady, Mrs. X, living in the house. He was generally aware that Mrs. X was caring for a person (Grace) and that Mrs. X's husband was deceased. Sergeant Epsilon knew of Mrs. X's

daughter who had worked locally for a time. Sergeant Epsilon was aware of Mrs. X's grandson (Alpha), who lived with her.

- 6.9 Sergeant Epsilon knew that Gamma used to drive Mrs. X around, although he did not know that he was her nephew at this stage or that he lived in the house. Sergeant Epsilon thought Gamma either lived elsewhere within the village or close by it.
- 6.10 With regard to Beta, Sergeant Epsilon told the Commission that he knew that he lived in a "*lean-to affair building*" at the back of the X's house. He said that he knew that Beta worked locally and, in this connection, called to Sergeant Epsilon's house from time to time. Sergeant Epsilon said that he would see Beta regularly enough "*around the place*". He said that Beta had never come "*under my notice on any other matter*". With respect to Mr. Smith's note, Sergeant Epsilon said that he did not know if Beta was or was not related to Mrs. X or what their connection was. Sergeant Epsilon spoke with Beta about his general background at a later stage and shared information on this with Mr. Smith.
- 6.11 Sergeant Epsilon confirmed that the "1996 notification" to which Mr. Smith's note referred was not something he was aware of as the Sergeant in the Village in 2007. This is a reference to the notification received by the South Eastern Health Board in March, 1996 from the mother of a child who had stayed with Family X in the 1980s and which is reported upon in Chapter 7 of the First Substantive Interim Report.
- 6.12 At the time of this telephone call with Mr. Smith, Sergeant Epsilon knew Mrs. X to see in passing when she was down the town shopping or in the post office, with Mr. Gamma driving her. He told the Commission that there was nothing remarkable about Mrs. X, whom he described as an "*elderly woman*". Sergeant Epsilon had never spoken with her and never had any occasion to call to the house.
- 6.13 With respect to the final paragraph of Mr. Smith's note of their telephone call, Sergeant Epsilon thought that Mr. Smith was talking about "*seeing how he could have placed [Grace] into full time care possibly. Something like that*". In

this regard it was general background that Mr. Smith was seeking from Sergeant Epsilon and Sergeant Epsilon said that he provided this to Mr. Smith.

- 6.14 Sergeant Epsilon was not requested by Mr. Smith to do anything further arising from this telephone conversation.

7. The incident of 20th August, 2008

Report from Day Service Provider A

- 7.1 On 20th August, 2008, staff at Day Service Provider A observed Grace to have bruising to the area around her right eye. A member of staff contacted Mr. Smith to draw this to his attention. Volume 1 and Volume 3 (the Care Volume) report more fully on the communications between Mr. Smith and Day Service Provider A personnel with respect to both Grace and Mr. Smith's note of his response to this notification.
- 7.2 Mr. Smith telephoned Waterford Garda Station and spoke to Sergeant Annette Leahy and Garda Christine Keniry. He made a note of that contact in the following terms:

"T/c to Waterford Garda Station: I spoke to Garda Annette Leahy and then Garda Christine Keniry.

I outlined the concern and asked if there was any adult protection service in the Garda station that would look into this. After some consultation I was told that the matter would have to be dealt with locally via Clonmel ... I stressed that despite the historical concerns about the placement it was unclear how or where [Grace] had come by this injury.

Garda Keniry asked me if there was a concern over sexual abuse and I said that there had been, and that this matter had been reported to the Gardaí and that I had followed up on this last year.

We then had further discussion about [Grace's] rights and my duties in regard to bringing [Grace] to a medical examination. We agreed that this was implicit in my professional role. She also said that if there was bruising to the eye then there may also be a fracture to the nose and it would be best to have her checked out.

Garda Keniry said that she would pass the information on to the local area and they would have to look into it there next week.

She also queried why the Health Service Executive had not moved [Grace] out of the placement and I stressed that we were doing all we could to make this happen."

- 7.3 Mr. Smith told the Commission that he telephoned the Gardaí in Waterford because of what he had learnt from the staff in Day Provider Service A about Grace's having a "black eye". He considered this suggestive or possibly suggestive of a non-accidental injury. Mr. Smith had not attended at Day Service Provider A at that stage. Mr. Smith said that while he considered the injury to Grace to be suggestive of non-accidental injury, he was unsure of the legal basis for any intervention on their part, and that the reason he had contacted An Garda Síochána was to see if the HSE was allowed to bring Grace for medical examination and treatment.
- 7.4 At the time of the call, Garda Keniry was attached to Unit A, one of the regular policing units in Waterford station and her supervising sergeant was Sergeant Annette Leahy. She did not remember this particular call when giving her evidence to the Commission. Garda Keniry described the Communications Room, where such calls were taken, as extremely busy and said that one would deal with a telephone call and then move on to deal with the next call. Her evidence on the incident was by reference to her report, referred to below. She said that she thought that this was not an incident that was going to be investigated by the Gardaí in Waterford. As Garda Keniry explained in evidence, "*where an incident has taken place is generally where the incident would be investigated from*". In this regard, the Commission is satisfied that the information conveyed to the Gardaí by Mr. Smith centred on his view that

although it was unclear how or where Grace had come by this bruising, any incident had occurred at home.

- 7.5 At this time there was what Mr. Smith described as a gap in procedures, in that the HSE had not established any kind of working relationship with An Garda Síochána in adult protection matters, particularly about adults who lacked capacity. There was a system in place with respect to children under the “Children First” guidelines, whereby the Gardaí would be contacted in the event of a complaint with respect to a child, and an officer assigned to investigate. No such arrangement regarding communication between An Garda Síochána and the HSE was in place for vulnerable adults. Nevertheless Mr. Smith told the Commission that he found Garda Keniry and Sergeant Leahy to be helpful and pleased to assist in discussing matters with him and Garda Keniry confirmed that they would relay the matter to their counterparts in Clonmel. The Commission is satisfied that this is the way that the matter was left following this telephone call.

Attendance at Waterford Regional Hospital

- 7.6 Members of An Garda Síochána were not dispatched to attend at the hospital following Garda Keniry’s conversation with Mr. Smith. Mr. Smith did not request that the Gardaí attend with him. When she gave her evidence to the Commission, Garda Keniry could not recall if she had discussed with Sergeant Leahy the issue of whether Gardaí should attend the hospital. Garda Keniry explained that the dispatch of a patrol car would depend on the nature of the call. Garda Keniry said that it would have been her Sergeant’s decision as to whether or not to have members attend the hospital when Grace was being taken there for medical examination.
- 7.7 Sergeant Leahy had no recollection of this call or of having any discussion with Mr. Smith or Garda Keniry about the matter.
- 7.8 In this regard, bearing in mind the evidence of Garda Keniry, the Commission is satisfied that she had a conversation with Sergeant Leahy, possibly while Mr. Smith was on the telephone. It is not possible, at this stage, to establish the consideration (if any) given to whether or not any Garda member should be sent to the hospital.

- 7.9 After Mr. Smith completed his call to An Garda Síochána, he endeavoured to make contact with a social worker at the Waterford Regional Hospital. He told the Commission that, in his experience, hospital social workers had considerable experience in this kind of case. However, he was unable to make contact with any social worker there.
- 7.10 At 2.00 p.m. Mr. Smith visited Day Service Provider A where he met with both Grace and Ms D, the manager of the centre. He observed that Grace had what appeared to have been a yellow bruise under her right eye. He described it, in his notes, as *'fading'*. He also observed two small scabs on the edge of the bruise. He observed a number of small sores at the back of Grace's neck and behind her ears. He told the manager that he wanted to take Grace to hospital to determine, according to his note made at the time, *"if the mark to the eye was bruising"*.
- 7.11 Mr. Smith returned briefly to his office to confer with the Coordinator of Disability Services. Mr. Smith told the Commission that she would go along with his judgement to bring Grace to the hospital for examination.
- 7.12 Mr. Smith returned to Day Service Provider A where he was introduced, for the first time, to a social worker who had newly been appointed to Day Service Provider A.
- 7.13 Mr. Smith gave evidence of some discussion at this meeting on aspects of the situation, including making contact with Mrs. X. It appeared to Mr. Smith, as indicated in his notes, that Mrs. X was, indeed, contacted by telephone. Mr. Smith noted at the time that Mrs. X *"had no problem with [Grace's] going to the hospital to be checked out"*. The evidence before the Commission indicated that Mrs. X was contacted by telephone.
- 7.14 Some of this discussion with Mrs. X was noted more particularly by Ms D in notes made by her at the end of that day. These notes recorded that Mrs. X was aware of the injury, having observed it on the previous Friday. Mrs. X had endeavoured to treat the injury with *"powder"*. Mrs. X did not know how the injury had been sustained but was concerned that Grace sometimes banged her head on the bus and she thought that that was what had happened.

- 7.15 Mr. Smith told the Commission that he learnt at this meeting, as his notes indicated, that there had been a conversation between a senior staff member of Day Service Provider A and the driver of the bus that brought Grace to Day Service Provider A from her home each day. Mr. Smith recorded his understanding of that conversation at that time as being that the driver of the bus had stated that Grace had hit her head against the window of the bus on the previous Thursday. Mr. Smith's note indicated that there was a discussion at the meeting as to whether such an incident would be consistent with "*a black eye*".
- 7.16 When Mr. Smith was asked if there was anything he could add in relation to the information which he had noted as coming from the bus driver and which would assist the Commission, he answered, "*I suppose the discussion about what is the likelihood of a non-accidental injury*".
- 7.17 Mr. Smith went on in his evidence, however, to say that from his own experience and some training he had received over the years, he thought "*it was very difficult to judge bruises*". He told the Commission that, "*[i]t can be very very difficult particularly if there is no history given. But there's some bruises are more likely to – on some sites of the body – are more likely to be non-accidental than others*".
- 7.18 He went on in evidence to say:
- "[s]o, the rim of the eye on the inside of the eye would be less likely to be accidental injury because, you know, just from common sense if I was to bang my head-on the desk now, for example, you know it would be outer part of my forehead that would be making contact with the desk"*.
- 7.19 Mr. Smith told the Commission that these were "*the kind of discussions which social workers have a lot of those discussions with medical professionals. So that would be a very familiar discussion to me.*"
- 7.20 Mr. Smith, accompanied by a staff member from Day Service Provider A, then brought Grace to Waterford Regional Hospital for examination, arriving there

just before 4.00 p.m. There was no further contact made by the HSE with An Garda Síochána on that day.

7.21 These events and interactions, including the interactions indicating that the injury may have been sustained while Grace was travelling on the bus, are considered in more detail and reported upon by the Commission in the context of the terms of reference with respect to the care of Grace and the overall management and decision-making in her case, within the HSE over this period in the Care Volume.

7.22 Commenting on matters at the Commission, Garda Keniry referred to the fact that Mr. Smith had stated, during their telephone call, that he would bring Grace to hospital to have her assessed, and she observed that, *"I think it would be safe to assume that if medical staff had felt the cause was not of an accidental nature then again we would have been contacted and the cause of the bruising would be recorded by a medical practitioner"*. In fact, the evidence provided to the Commission was that the doctor who did examine Grace could not say whether the bruising was accidental or non-accidental in origin.

8. Garda investigation of the incident of August, 2008

8.1 The incident reported on 20th August, 2008 was not recorded on the Garda PULSE system. Garda Keniry accepted that, under the PULSE guidelines in force at the time, there was a duty on her to record the matter on PULSE. However, she gave evidence that, in two respects, this was not the practice adopted in Waterford with respect to such a report at the time.

8.2 First, Garda Keniry told the Commission that the practice in Waterford was that *"the Garda who would attend the scene out of the station that would attend would put the incident on PULSE itself, the investigating Guard"*. In this regard, Garda Keniry pointed out that she had submitted her report to her sergeant for an investigating Garda to be assigned to it. Her understanding was that this would be an investigating member in the Tipperary Division. Garda Keniry said that if a PULSE incident needed to be created by her, this should have been brought to her attention at the time.

8.3 Secondly, Garda Keniry said that as they had no confirmation that an assault had actually taken place, she would not have put an incident on the PULSE system. Garda Keniry said that this was the practice in Waterford in 2008 even though the PULSE User Manual provided that an incident – being “*any occurrence which requires follow up activity by a Garda once he or she becomes aware of it*” – be recorded.

8.4 Related to this was the assertion by Garda Keniry that in respect of a “*sexual offence*”, it was only the investigating officer who could place an entry on the PULSE system. This instance of bruising in August, 2008 was not reported as a suspected sexual offence.

8.5 Garda Keniry told the Commission, with regards to PULSE, that:

“[t]oday, as opposed to back in 2008 certainly an incident would have been created. Back in 2008 it wouldn't have been the practice, if it was required of me then I would have certainly have created maybe a more minor incident for it but it wasn't asked of me or required of me at that time.”

8.6 On the first point raised by Garda Keniry, Sergeant Leahy confirmed to the Commission that it was the practice in Waterford at the time that an incident would be recorded on PULSE by the Garda who attended at the scene, the investigating Garda, rather than the Garda who took the call.

8.7 On the second point, Sergeant Leahy told the Commission that there was an unwritten instruction at the time that incidents were not put on the PULSE system unless there was evidence that there was a crime committed and a written statement of complaint had been received. In this regard, Sergeant Leahy set out that if an incident of assault was put on the PULSE system and then had be made invalid, it would still be counted in the crime figures. Sergeant Leahy said that if she was not aware of the full nature of the complaint, it would not be put on PULSE until the correct category was known and, in general, this would be done when a statement of complaint was received.

8.8 Superintendent Christopher Delaney was the District Officer in Waterford at this time. He was promoted to the rank of Superintendent in February, 2007 and

appointed to the Waterford District in December, 2007. In his evidence to the Commission, Superintendent Delaney was clear that such practices as described by Sergeant Leahy and Garda Keniry did not exist. He emphasised that any such practices would remove the underlying purposes and benefits of the PULSE system and were contrary to the provisions of the PULSE User Guide. He also stressed that the entry of an incident on the PULSE system provided the necessary material for properly informing the daily and weekly accountability meetings.

- 8.9 Superintendent Delaney did not accept that there was any provision that a "sexual offence" could only be entered on the PULSE system by the investigating member. While restrictions existed in relation to the rank of officers or members, other than the investigating member, who were permitted to access an existing PULSE entry in relation to a sexual offence, at the initial point of entering an incident on the PULSE system there was, in his view, no distinction between a reporting member and an investigating member.
- 8.10 In his evidence, Superintendent Delaney expressed the view that Sergeant Leahy was confused as between the issues of creating an incident on the PULSE system and the categorisation of the incident. In his view, the obligation to create the entry on the PULSE system was the crucial requirement. He said that the categorisation could always be changed as further information came to light.
- 8.11 In response to the point made by Sergeant Leahy that invalidated incidents would still be included in the crime counting figures, Superintendent Delaney told the Commission that his understanding was that if an incident was invalidated it was not counted. In those circumstances a small letter "i" would appear on the PULSE incident along with the reason for the invalidation. Once that letter "i" was there, he said that *"it would not be counted"*.
- 8.12 In light of the evidence of Superintendent Delaney on this issue, the Commission cannot be satisfied that the "practices" referred to by Sergeant Leahy and Garda Keniry were practices that were established in the Waterford District, or that they superseded the operation of the Crime Counting Rules at the relevant time. On the face of it, however, this demonstrated a level of

confusion in the District concerning the proper application of the Crime Counting Rules at that time.

- 8.13 The fact that the incident was not recorded on PULSE had the effect that it did not appear on the system in the District Office in Clonmel and therefore could not have been included for discussion at a daily / weekly accountability meeting. Had this occurred, it is an item that, in the normal course of practice as described to the Commission, should have been included for discussion at a daily/weekly accountability meeting in Clonmel District where the District Officer and his team, including the members of the Detective Unit, would normally have been in attendance.
- 8.14 As the incident was not recorded on PULSE, the automatic report reminder facility built into that system was not available. This is a matter discussed in more detail later in this Volume.

Garda Keniry's report

- 8.15 Garda Keniry's report of the incident which was submitted to Sergeant Leahy set out the following:

"Sergeant I/C,

Unit A

Re: alleged Assault of [Grace], [Address], reported by Ian Smith of the HSE.

In relation to the above, today 20th August Mr. [Iain] Smith a social worker for Vulnerable Adults in Waterford contacted the Garda Station to say that a client by the Name of [Grace], 27 years had received Bruising to her face recently and that the staff have also noticed that [Grace] has bruising on other parts of her body over a period of time.

[Grace] is legally an independent adult with independent rights and not legally in the care of the HSE. [Grace] is not capable of being independent as she has a very severe mental disability where she can not communicate with anyone. And is not capable of looking after herself. [Grace] is still residing with her foster care mother [Mrs. X.]

[Iain] Smith has reason to believe that [Grace] is being abused physically and would have serious concerns about her being sexually abused. He will bring her to Waterford Regional Hospital to have her bruising assessed and to establish the cause.

[Iain] Smith can be contacted on [office number] or [mobile number]

Please forward this report to the relevant Garda station for investigation.

Signed_____ [Garda Number redacted]

(Christine Keniry)"

Report of incident transferred from Waterford District to Clonmel

- 8.16 On receipt of Garda Keniry's report on 22nd August, 2008, Sergeant Leahy arranged for it to be sent through the office of the Sergeant-in-Charge in Waterford Sub-District, Sergeant Laurence Langton, to the Sergeant-in-Charge Clonmel Sub-District for investigation. Sergeant Langton had no memory of receiving the report when giving evidence and told the Commission that if it had come to him, it would just have been forwarded on as requested. He said that unit sergeants would send him documents to be forwarded. Sergeant Langton told the Commission that he would not know what was under investigation and would just be facilitating the request. Sergeant Langton gave evidence that irrespective of what was contained within any documents he was asked to forward, as Sergeant-in-Charge he would comply with the specific request he received in relation to the documents forwarded to them.

- 8.17 The role of Sergeant-in-Charge is poorly defined in the Garda Code, which only deals with the duties and responsibilities of sergeants or other members-in-charge of Sub-Districts. Sergeant Langton said that this lack of definition had been a matter of some concern for sergeants for some time.
- 8.18 Sergeant Leahy could not recall whether she had spoken to an Inspector or to the District Officer, Superintendent Delaney, about this particular call and there was no evidence before the Commission of any communication of the matter to senior members or officers in Waterford Garda Station over this period.
- 8.19 On the same day, 22nd August, 2008, Mr. Smith telephoned Garda Keniry. He made a note that he was told that the report had been forwarded to Clonmel for a Garda to be allocated to the case. Mr. Smith noted that he emphasised “*the sensitivity of the case*” and asked that the Garda involved speak with him first, and that Garda Keniry advised him that that would be the case.

Intercommunication between stations in different Garda Districts

- 8.20 In enquiring into the sharing of information among officers and members of An Garda Síochána with respect to Grace, an issue of relevance to the Commission’s investigation was the manner in which the report prepared by Garda Keniry with respect to the incident of 20th August, 2008 was communicated internally from Waterford District to Clonmel District for investigation.
- 8.21 As referred to earlier, Chapter 47.13 of the Garda Code in operation at the time provided for the following:

“Intercommunications between Stations:

(1) As a general rule, communications between Stations in different Districts should pass through the District Office. Members-in-Charge of Stations may, however, communicate with one another directly by phone or otherwise in respect of urgent matters such as absconding offenders or any matter of routine nature”.

- 8.22 The Garda Code did not make any specific provision with respect to the transfer of a matter between Districts which was reported to An Garda Síochána in one District but for investigation in another District.
- 8.23 The Commission's findings with respect to the proper manner of transmission of such a matter from one District to another are set out later in this Volume, following the Commission's consideration of the evidence with respect to communication internally within An Garda Síochána with respect to the incident of March, 2009.

Receipt of report in Clonmel

- 8.24 Garda Keniry's report was transferred by Sergeant Langton in Waterford and was addressed to the Sergeant-in-Charge, Clonmel. It was received in the office of Sergeant Tom O'Dwyer, who was then the Sergeant-in-Charge of Clonmel Sub-District.
- 8.25 Clonmel District was part of the Tipperary Division and comprised a number of Sub-Districts. Clonmel Sub-District, which in effect comprises the town of Clonmel only, was one of those Sub-Districts. It is important to note that Clonmel District and Clonmel Sub-District are distinct entities, with the latter, in hierarchical terms, forming part of the former. Clonmel District consisted at that time of a wide geographical area including Clonmel town. Sergeant O'Dwyer was not Sergeant-in-Charge of Clonmel District.
- 8.26 At the time, Superintendent Eunan Dolan was the District Officer in Clonmel District. Inspector James Bowen was assigned to that District as District Inspector.
- 8.27 An issue arose at the Commission as to how the report from Garda Keniry should have been dealt with when it was received by Sergeant O'Dwyer in Clonmel Garda Station. In particular, there was disagreement between the evidence of Sergeant O'Dwyer, on the one hand, and that of Superintendent Dolan and Inspector Bowen, on the other, as to whether Sergeant O'Dwyer should have forwarded the report upwards for Inspector Bowen's attention, rather than sending it directly to Sergeant Epsilon.

- 8.28 Neither Inspector Bowen nor Superintendent Dolan was made aware of the receipt of Garda Keniry's report in Clonmel Station. Inspector Bowen told the Commission that he would have expected Garda Keniry's report to have been brought to his attention by the Sergeant-in-Charge in Clonmel, Sergeant O'Dwyer, when it was received there in August, 2008.
- 8.29 Where a report of an incident, not recorded on PULSE, was transferred from another Division into his District, Superintendent Dolan told the Commission that he *"would have expected that to have been brought to my attention by the Sergeant-in-Charge in Clonmel who saw the correspondence going through..."*
- 8.30 In giving this evidence, neither Inspector Bowen nor Superintendent Dolan made any distinction arising from Sergeant O'Dwyer's position as the Sergeant-in-Charge of Clonmel Sub-District, as set out below.
- 8.31 In this regard, Sergeant O'Dwyer's core point was that the documents should not have been directed to him as his position was Sergeant-in-Charge for the Sub-District of Clonmel, encompassing Clonmel town and not for the entire Clonmel District, as part of the Tipperary Division.
- 8.32 Sergeant O'Dwyer gave evidence that there were other Sub-Districts around his Sub-District of Clonmel, including Sergeant Epsilon's Sub-District. He said he was one of maybe six sergeants who all had their own areas explaining that, *"[e]ven though I was stationed and my offices were in Clonmel I didn't have responsibility for the whole District, I just had responsibility for my own Sub-District."*
- 8.33 Sergeant O'Dwyer emphasised that as Sergeant-in-Charge of a Sub-District he was in the same position as Sergeant Epsilon was in charge of another Sub-District. He agreed that the Clonmel Sub-District was (by far) the busiest. Sergeant O'Dwyer said that although Clonmel station was the District Office, he was a Sub-District sergeant. He said that when the correspondence came to his office, it would have been looked on as correspondence that should have gone to the Sergeant-in-Charge of the Village as opposed to the Sergeant-in-Charge of Clonmel Sub- District. Sergeant O'Dwyer said that that was why it was redirected immediately that day to Sergeant Epsilon.

- 8.34 In this regard, Sergeant O'Dwyer told the Commission that the correspondence was misdirected from Waterford and that it should either have been sent directly to Sergeant Epsilon in the Village or, in his opinion, *"more properly being sent through the District Officer in Waterford to the District Officer in Clonmel Garda Station"*.
- 8.35 Sergeant O'Dwyer said that it would have been then up to Sergeant Epsilon to take the appropriate action from there and to discuss the matter with Inspector Bowen or Superintendent Dolan. He said if a document was pertaining to his Sub-District then he would have gone to the Inspector or the Superintendent and discussed it with them.
- 8.36 Sergeant O'Dwyer gave evidence that all matters of communication at sergeant level did not go up through the Superintendent's office within the District. He said it was only if he was sending correspondence to another District that all correspondence would automatically go up through the Superintendent's office. At Sub-District level, Sergeant O'Dwyer said the correspondence went from sergeant to sergeant.
- 8.37 Sergeant O'Dwyer told the Commission that there was actually no District Sergeant. In this regard, while Sergeant Langton had used the term *"the District Sergeant"* in his evidence, it was confirmed on behalf of An Garda Síochána at the Commission that there was no role within An Garda Síochána carrying the rank and additional responsibilities as District Sergeant.
- 8.38 Sergeant O'Dwyer did not accept that Inspector Bowen's evidence or Superintendent Dolan's evidence was correct in stating that he should have brought the report to the attention of either of them. Superintendent Dolan later informed the Commission that he accepted Sergeant O'Dwyer's position on this issue.
- 8.39 An Garda Síochána was unable to clarify for the Commission whether the correct procedure at the time would have been for Sergeant O'Dwyer to bring Garda Keniry's report to the attention of either Superintendent Dolan or Inspector Bowen in the first instance. In the absence of such clarity, and on the evidence reported above, the Commission is not satisfied that there was a clear procedure or protocol in place requiring Sergeant O'Dwyer to bring Garda

Keniry's report to the attention of his superior officers rather than to pass the report on to Sergeant Epsilon for his attention, or that Sergeant O'Dwyer was in breach of procedure in so doing.

- 8.40 The difference in the view taken by members of An Garda Síochána in the District Office in Clonmel as to what was the correct procedure with respect to sharing of information (the report) internally in 2008 was indicative of an absence of clarity within An Garda Síochána in Waterford and Clonmel at the time regarding communication of information between different Garda Districts and Divisions. This is a matter that is considered further below.

Receipt of report by Sergeant Epsilon in the Village, August, 2008

- 8.41 Sergeant Epsilon received Garda Keniry's report towards the end of August, 2008. From the time that he spoke to Mr. Smith on 18th September, 2007 and the receipt of Garda Keniry's report in August, 2008, there had been no contact by the HSE with Sergeant Epsilon.
- 8.42 The evidence received by the Commission as to communication between Sergeant Epsilon and Mr. Smith about this report was somewhat uncertain. Neither Sergeant Epsilon nor Mr. Smith's recollections were clear on the issue and there was no record of contact between them. Sergeant Epsilon initially said that he had definitely spoken to Mr. Smith on one of the telephone numbers provided on Garda Keniry's report. Sergeant Epsilon could not recall the content or extent of their discussion when giving his evidence to the Commission and, in endeavouring to do so, his recall was somewhat conflated with subsequent discussions he had with Mr. Smith, referred to further below. He was, however, uncertain about the contents of any such telephone discussion at the time, although he remained of the belief that he had a conversation on the telephone with Mr. Smith in 2008. His recollection, tied to the belief that he had telephoned Mr. Smith, was that there was no statement of complaint forthcoming from Mr. Smith with respect to the matters in the report.
- 8.43 Sergeant Epsilon's recollection of the position at that stage was as follows:

“I believe that Mr. Smith now, and this just my belief and my remembrance, that he was attempting to have [Grace] made a Ward of Court and taken into care full-time, but other than that that’s where it finished with me.”

- 8.44 His recollection was that Mr. Smith did not come back to him further with respect to this report.
- 8.45 In his evidence to the Commission on whether there was communication between Sergeant Epsilon and himself regarding this report, Mr. Smith said that while it was recorded in the notes of the meeting of the HSE’s Vulnerable Adult Committee of 14th September, 2009 that he would follow up with Sergeant Epsilon, he could not say at the time of giving his evidence whether or not he did follow up on this report. Mr. Smith told the Commission that, had he done so, he would have normally kept a note of the conversation, and there was no note on the file. The only reference to material of this nature in any Vulnerable Adults Committee’s minutes relates to those of a meeting of that committee held on 14th September, 2009, and reads *“Update. No response from Gardaí. [Mr. Smith] will follow up.”* This was after the second incident relating to Grace reported upon in this Volume, that of 27th March, 2009, and was followed by a meeting between Mr. Smith and Sergeant Epsilon on 19th October, 2009. This meeting will be referred to later.
- 8.46 Mr. Smith also pointed out that there was no complaint or statement to An Garda Síochána arising out of Grace’s visit to Waterford Regional Hospital on 20th August, 2008, and he distinguished this from the occasion of the incident reported in March, 2009, which is referred to later in this Volume. In this regard, Mr. Smith said that he was not surprised that this report in August, 2008 was not treated as a crime by An Garda Síochána. It could not be stated by the hospital as to whether the bruise was accidental or non-accidental. Mr. Smith told the Commission that he had a concern about what he, Mr. Smith, considered to be inconsistent explanation for the bruising, saying, *“but I didn’t think it was something, I never really thought that the Garda would take that on as a crime”*.

8.47 Mr. Smith said that the issue was “*more a concern of neglect and allowing an injury like that to have occurred and not being clear in the exchanges between [Day Service Provider A] and [Mrs. X] as to what had occurred.*”

8.48 In this regard, Mr. Smith recalled generally that there were times when he talked to Sergeant Epsilon and told the Commission:

“I think I got the impression that there wasn’t particular evidence that a crime had been committed given that we were looking at the balance of probabilities of what might have happened in terms of there being the concern about the inconsistent explanation.”

8.49 The Commission considers that Sergeant Epsilon’s recollection of his understanding of where matters stood on Grace’s case within the health board at this time in 2008 is correct.

8.50 The Commission cannot establish on the evidence that there was a telephone call between Sergeant Epsilon and Mr. Smith following Sergeant Epsilon’s receipt of Garda Keniry’s report.

8.51 Sergeant Epsilon did not go on to carry out an investigation into what was set out in Garda Keniry’s report. He told the Commission that his general belief at the time was that he needed a statement of complaint from someone before commencing an investigation. However, Sergeant Epsilon agreed at the Commission that the absence of a statement of complaint on behalf of Grace was not a reason in itself to hold up an investigation of such a report. Sergeant Epsilon was candid in his evidence that he was the member responsible for investigating the report but, apart from the steps taken, as described below, did not do so.

Sharing of information within An Garda Síochána

8.52 Daily / weekly accountability meetings for Clonmel District in the Tipperary Division were held by Superintendent Dolan, who was the District Officer in Clonmel. Sergeant Epsilon attended the weekly meetings where sergeants from the Sub-Districts would meet Superintendent Dolan, who was the District

Officer, and Inspector Bowen to discuss issues arising in their areas. Sergeant Epsilon did not raise this report or bring it to the attention of his superior officers at any such meeting. Because of the manner in which the report had been channelled to Sergeant Epsilon in the Village, having been simply forwarded by Sergeant O'Dwyer on receipt in Clonmel Station, Sergeant Epsilon's superior officers in Clonmel were unaware of the report. There is a reference in the Correspondence Register for Waterford Garda Station to the report's being forwarded to the Sergeant-in-Charge in Clonmel, to "*fwd for investigation*". The Commission is satisfied that the report was forwarded as intended although the documentary record for this was lost due to a Garda computer malfunction.

- 8.53 Sergeant Epsilon accepted responsibility at the Commission for not taking any further steps with respect to Garda Keniry's report, including raising it with his inspector or District Officer at this time. He explained to the Commission that he was experiencing serious personal problems around that time. The Commission is satisfied that these were not matters that had been brought to the attention of his superior officers or that those officers were then aware of them. The Commission is satisfied that the evidence given by Sergeant Epsilon with respect to these personal problems was relevant, correct and accurate. These problems are reported upon in more detail later in this Volume, insofar as appropriate, in order to gain an understanding of what was happening.
- 8.54 In the course of his evidence, Sergeant Epsilon told the Commission that, at some stage, he did do what he described as "*a bit of surveillance*" on Mrs. X's house to see who was coming and going. This evidence was somewhat vague in nature. Sergeant Epsilon was unclear in his evidence as to whether it was at this time he carried out this surveillance or at a later stage, after he had spoken with Mr. Smith in October, 2009. It may have occurred at this later stage. There were no records of this activity. Sergeant Epsilon said that this was done in passing and some evenings he went up to observe the house in his own car. Nothing of concern arose from this surveillance. He told the Commission that he observed nothing untoward. Sergeant Epsilon did not approach the house or speak to anyone in connection with these trips.
- 8.55 The Commission considers that it is possible that if the report of Garda Keniry had been brought to the attention of Superintendent Dolan or Inspector Bowen,

they might have given direction and assistance to Sergeant Epsilon as to any enquiries to be made of the HSE or investigation to be carried out into the matters in Garda Keniry's report. However, it is a matter of considerable uncertainty/speculation as to what the nature or outcome of such an investigation in 2008 would have been, having regard to the factors highlighted with respect to this incident in the evidence of Mr. Smith, as set out above.

- 8.56 The outcome of the Garda investigation carried out into this and other issues with respect to Grace is reported upon later in this Volume.

9. The incident of 27th March, 2009

Injuries to Grace noticed at Day Service Provider A

- 9.1 On 27th March, 2009, Grace attended Day Service Provider A. She was transported there from Mrs. X's on her usual bus. At approximately 10 a.m., as a result of having diarrhoea, which was not an unusual event, Grace was showered. While showering her, staff noticed some bruising to her chest and thigh area and some scratches on her body which had not been reported in the service two days earlier when she had gone swimming. Mr. Smith was contacted and he attended Day Service Provider A at approximately noon that day.
- 9.2 Mr. Smith had a concern that the bruising was possibly sexual in nature and telephoned the Emergency Department of Waterford Regional Hospital, which recommended discussing the matter with An Garda Síochána, as a referral to the SATU might be appropriate given the nature of the marks as described by Mr. Smith.

Gardaí contacted and attend Day Service Provider A

- 9.3 Mr. Smith telephoned Waterford Garda Station and was told that members would attend Day Service Provider A around 2.00 p.m. Garda Mary Murphy and Garda Jenny Dunne, who were attached to Unit D, were on patrol car duty and were dispatched to attend. Both were very junior members at the time. Garda Murphy, while being fully attested, was still in the fourth month of her

probationary period. Garda Dunne had completed her probation about a year earlier.

- 9.4 That day Garda Dunne was the driver and Garda Murphy the observer. They operated on a call by call basis, in that the driver took responsibility for the first call and the observer for the second call, and so forth. Garda Murphy was the member who took responsibility for this particular call. At approximately 3.40 p.m. Garda Murphy and Garda Dunne arrived at Day Service Provider A and were informed of what had been observed by staff. They advised that they would consult with their sergeant as regards the appropriate steps to be taken and report back by 5.00 p.m.
- 9.5 There were two supervising sergeants assigned to Unit D at this time, Sergeant Carmel Banville and Sergeant Michael Whelan. On this particular day, and for the next four days, Sergeant Banville was the supervising sergeant as Sergeant Whelan was on annual leave.
- 9.6 In their evidence to the Commission, neither Garda Murphy nor Garda Dunne could be sure if they returned to the station or if contact was made with Sergeant Banville over the telephone. It was Garda Murphy who spoke with Sergeant Banville. She could not recall the details of the conversation but assumed she would have outlined the facts and sought advice as to how best to proceed.
- 9.7 Sergeant Banville recalled speaking to Garda Murphy on the telephone. She said that she would have advised Garda Murphy in relation to whatever queries she had as to how to proceed. Sergeant Banville could not remember the specific queries but said that she was aware the query was in relation to a young woman who had presented with bruising and that she was non-verbal.
- 9.8 At 5.00 p.m. Garda Murphy and Garda Dunne returned to Day Service Provider A. They advised that Grace be taken to the Emergency Department of Waterford Regional Hospital and, following the outcome of the initial examination, then to consider whether a referral to the SATU was appropriate.
- 9.9 Sergeant Banville was not sure in her evidence that she would have given the advice in relation to the Emergency Department and was not quite sure where

that had come from. However, she said, *“certainly if there was a suggestion that there was a sexual assault or if there was any suggestion that a further investigation was required then I would have given that advice in relation to SATU”*.

Grace taken to the Emergency Department

9.10 Grace was subsequently taken to the Emergency Department at Waterford Regional Hospital. She arrived at approximately 5.25 p.m. Clinical notes from the doctor in that department recorded *“suspicious bruising and scratches on breasts and thighs. Plan; Advised carer/social worker that injuries are suspicious in nature and that they should contact the police and sexual assault unit”*.

9.11 An Garda Síochána was again contacted and Garda Murphy and Garda Dunne attended the hospital at approximately 8.30 p.m. Garda Murphy requested that Mr. Smith make a statement for the purpose of referring Grace to the SATU. This was required as Grace could not communicate, and as Garda Murphy explained, *“something had to be put in writing ... to justify the exam taking place on [Grace].”*

9.12 In his statement to Garda Murphy that night, Mr. Smith outlined the following:

“[m]y name is Iain Smith and I work at the above address. I am a Social Worker Team Leader for vulnerable adults with the HSE in Waterford. My role is to deal with the protection of adults with intellectual disabilities who by reason of their circumstances are vulnerable to abuse. I have been dealing with concerns about [Grace] since August 2007. In my professional capacity I was contacted by staff at [Day Service Provider A] this morning. The staff had concerns that [Grace] had bruising that was not explained and merited further medical investigation. We presented [Grace] this afternoon to A&E at WRH, I have been informed by the doctor that saw [Grace] that there were reasons to regard the bruising and other injuries that [Grace] may have on her body as suspicious of non-accidental injury. Due to [Grace’s] intellectual disability (in the profound range) she is not

able to communicate how she received these injuries, therefore in my professional capacity I am making this complaint on her behalf as I would like the Gardaí to investigate whether or not [Grace] has been the victim of a crime. In terms of the type of crime which [Grace] may be a victim of I would be concerned that this may include a physical assault or an assault of a sexual nature. Given the position of her bruising. This statement has been read over to me. It is correct. I do not wish to make any alterations or additions to it. I accept the contents of this statement."

Examination at the Sexual Assault Treatment Unit

9.13 Between approximately 9.25 p.m. and 11.00 p.m., Grace underwent a forensic medical examination at the SATU. This was conducted by Dr. Mary O’Gorman with a nurse assisting. When the examination was finished, Garda Murphy took possession of forensic samples and photographs, which she placed in a sealed evidence bag. Both she and Garda Dunne then left the hospital and returned to the station.

9.14 In the SATU records of the examination, the section for detailing the clothing given to An Garda Síochána during the course of the examination was filled in as “N/A”. Garda Murphy explained this by saying:

“[a]t the time this procedure was taking place in Waterford Hospital, while there was concerns about the marks on [Grace’s] body, there was no hard and fast evidence or complaint of a sexual nature at the time. Even the examination at A&E said that the injuries may be non-accidental, but there was never any definite complaint that there had been a sexual assault after taking place.”

9.15 Garda Murphy said that generally:

“if a person presents at the SATU within a certain period of time of an assault taking place, then there may be evidence there. If a person presents at the SATU a number of days after an

assault taking place where there has been changes of clothing, then you wouldn't take the clothing in that situation."

9.16 Garda Murphy recorded in her written report that:

"Dr. Gorman said that the bruising present on [Grace] were more than 18 hours old".

9.17 It was in these circumstances that the section in respect of clothing in the SATU records was marked 'n/a'.

10. Collating information in respect of the incident of 27th March, 2009

PULSE incident created

10.1 The next day, Saturday 28th March, 2009, Garda Murphy was on duty from 2.00 p.m. to 10.00 p.m. and Sergeant Banville was her supervising sergeant. At 9.10 p.m. that night, the incident of 27th March, 2009 involving Grace was recorded by Garda Murphy on PULSE. The incident was categorised as *"Attention and Complaints"*. Garda Murphy was recorded as the reporting Garda. No investigating Garda was recorded at that point. The location the incident occurred at was recorded as Day Service Provider A, Waterford and the narrative description of the incident read:

"Iain Smith reports suspicious bruising to [Grace]. [Grace] attends [Day Service Provider A] [Address]. Female was subsequently taken to WRH and examined by doctor and SATU unit."

Location

10.2 Garda Murphy told the Commission that *"the reason when the incident was created that I was on as reporting [Garda] was because it was believed to have taken place in [the Village]."* This was on the basis of how matters had been reported to the Gardaí. She said, *"if we were satisfied that the incident took place within Waterford, I would have been automatically appointed as investigating."* She agreed that the *"general consensus"* at the time was that if

anything had happened to Grace, it had happened at home. Garda Murphy was not able to explain why the location for the incident was recorded as Day Service Provider A. She surmised that it was because they went to Day Service Provider A, where the incident was reported. Garda Murphy agreed that “*reported at*” was not the same as “*occurred at*.”

- 10.3 Having regard to the view that the stated belief at the time was that the incident had taken place in the Village, the Commission is satisfied that the appropriate location to have entered on PULSE was Grace’s home address at Family X. The incident should then have automatically appeared on the PULSE system in Clonmel as an incident having occurred in that District. The Commission is satisfied on the evidence that, in the normal course of events within An Garda Síochána, it is likely that the incident would then have been included in the PULSE matters for discussion at a daily/weekly accountability meeting. At this meeting Superintendent Dolan and his team, including Inspector Bowen and members of the detective unit, should, in the normal course, have been alerted to the complaint.
- 10.4 On 29th June, 2009 there was a Divisional Boundary realignment which had the effect that the Village Garda Sub-District moved from being part of Clonmel Garda District to being part of Thomastown Garda District. As part of that process, all PULSE incidents from Clonmel relative to the Village were transferred by the Garda IT department from the Clonmel PULSE system to the Thomastown PULSE system. The incident did not appear on Clonmel’s system because the location was recorded as being in Waterford.

Categorisation / classification

- 10.5 Sergeant Banville confirmed that her view was that the opinion of the doctor who examined Grace in the Emergency Department that her injuries may have been non accidental was not enough at the time to categorise the incident as a crime on PULSE. She went on to say that “*...the view I held at the time was that there was insufficient evidence to warrant it being categorised as a crime, and therefore, it was categorised as ‘Attention and Complaints’ as was standard practice at the time.*” Sergeant Banville also told the Commission that, looking at the Crime Counting Rules for PULSE, the threshold for recording the incident on PULSE as an offence probably would have been met, but she was

unsure at the stage of giving her evidence as to whether any such discussion was had at the time. Sergeant Banville said that the matter was being transferred to the Village Garda Station *“for a full investigation to establish whether or not a crime had occurred”*. In the relevant edition of the PULSE User Manual under the general heading *“Predefined Lists”*, Gardaí using the PULSE system were given assistance on the various categories under which incidents could be logged on the system. Under a sub-heading *“Incident Details”*, a list of 27 categories was given with illustrations of what was included in each category under a heading of *“Type”*. The category described as *“Attention and Complaints”* consisted of the following under the heading *“Type”* – *“Attention and Complaints, Bad Debts Civil, Bad Debts Criminal (Debtors Ireland), Civil Matters (other than bad debts civil) and Vacant Premises (houses, etc)”*.

10.6 As to why this incident was recorded on PULSE as *“Attention and Complaints”*, which was a non-crime category, Garda Murphy said that she would have sought advice from her supervisor, explaining that she was a junior Garda at the time and would not take *“two steps”* without checking what to do.

10.7 Sergeant Banville could not specifically recall any discussion about creating the PULSE incident, but accepted Garda Murphy’s evidence that she would have assisted her. As referred to above, the PULSE incident was created on Saturday night, 28th March, 2009, and Sergeant Banville said that *“that would have probably been following discussions as to what we were dealing with and trying to figure out what exactly we were dealing with.”* She went on to say:

“ ... I know at the time when we were unsure of what it was we were investigating the incident was put on as ‘Attention and Complaints’ and following investigations it would have been amended if necessary. That is my recollection of the way it was done at that particular time.”

10.8 Garda Murphy compiled a report of the incident on Monday, 30th March, 2009. That report is set out below. Garda Murphy told the Commission that the report was a synopsis of all of the information she would have passed on to Sergeant Banville at the time she consulted her when creating the PULSE incident.

GISC alert on PULSE Incident – Sunday, 29th March, 2009

- 10.9 As set out earlier, the Garda Information Services Centre (GISC) was staffed by civilians who entered the details supplied by members of An Garda Síochána in relation to reported incidents onto the PULSE system.
- 10.10 On Sunday, 29th March, 2009, Sergeant Banville and Garda Murphy were on duty from 6.00 a.m. until 2.00 p.m. At 8.29 a.m. GISC triggered an alert on the PULSE incident. The incident was marked “*reviewed/clarification*” along with the comments “*contact GISC to update and to reclassify if offence occurred.*”
- 10.11 Superintendent Delaney told the Commission that, “*to be fair to GISC they were doing their job correctly ... what they were doing was they were triggering an alert that this needs somebody to look at this incident and to consider is the classification correct or incorrect.*”
- 10.12 Superintendent Delaney said that this “*triggering*” by GISC was, clearly, directed not just at the investigating member but also at the Garda supervisor. When asked whether there was a distinction between the investigating Garda and the reporting Garda, Superintendent Delaney said:
- “[n]ot at that point. As time would go on you would flesh out where the case was going and who was going to take charge ... At that point reporting and investigating were the same ... for the purposes of the PULSE entries.”*
- 10.13 In referring to the Garda supervisor, Superintendent Delaney was referring to the unit sergeant.
- 10.14 The PULSE audit records disclosed to the Commission showed that after its creation on 28th March, 2009, the PULSE incident was not accessed by any officer or member of An Garda Síochána until 20th June, 2010, almost 15 months later.
- 10.15 When Sergeant Banville was asked why she had not accessed the incident, she said that it was her recollection that the alleged incident would have occurred in the Village. They would have gathered whatever information they

had in Waterford to send to the Village Garda Station to have the matter investigated, and therefore it would not have been a Waterford investigation. However, considering the Garda Code and PULSE guidelines at the Commission, Sergeant Banville agreed that the incidents created by members of An Garda Síochána on PULSE, irrespective of whether the matter was going to be transferred to another Division or not, were required to be reviewed by the unit sergeant.

- 10.16 Sergeant Banville indicated that it would have been common for queries to be raised by GISC about PULSE classifications and for those queries to be discussed at the daily/weekly meetings and whether the correct classification had been attributed to the incident when creating the PULSE entry.
- 10.17 Sergeant Banville told the Commission that normally the unit sergeants would look at the incidents on a daily basis and that “*it should have happened*” in this case. In relation to this incident, she said that if it was discussed at the daily meeting and clarification was required, the Superintendent would generate a report to either herself or Sergeant Whelan seeking clarification.
- 10.18 There was no evidence before the Commission that such a report was generated on this occasion. As will be seen, equally there was no evidence that the incident and, in particular, its classification were discussed at any daily or weekly meeting.

Daily/weekly accountability meetings in Waterford

- 10.19 Daily/weekly accountability meetings in Waterford were normally chaired by Superintendent Delaney and were attended by his clerk, the unit sergeant, and, if available, the District Inspectors, the Detective Inspector, Detective Sergeants, and the Sergeant-in-Charge of the station, as well as the Sergeants-in-Charge of community policing and crime prevention. Superintendent Delaney’s clerk kept a minute of the meetings. These records were retained for a period of seven years, after which they were destroyed.
- 10.20 The main source of information for the daily/weekly meeting was PULSE. Superintendent Delaney explained that the feeding of the PULSE information into the meetings allowed them to be able to deal with events more or less

contemporaneously with what had happened within the previous 24 hours or over a weekend. The Commission heard in evidence that in Waterford, the unit sergeant, who started work at 6.00 a.m., printed off the incidents from PULSE and went through them before the meeting. The meeting started at 10.00 a.m. Where an incident was recorded over the weekend, the practice in Waterford was that those incidents were ordinarily discussed at the Monday morning meeting.

- 10.21 Superintendent Delaney explained how this system was beneficial to the running of the District, as follows:

“... people can review PULSE incidents and sometimes the unit that may be put on an incident aren’t available, so for clarification purposes that unit sergeant that comes in to me on a Monday morning, let’s say, is vital, because they have perhaps have made a ‘phone call, they have made inquiries, they may be aware of it themselves. So you are depending on the verbal discourse at the meeting to explore what is in a narrative in an incident”.

- 10.22 He went on to tell the Commission:

“[i]t is key. Very important. ... and in actual fact, many of the tasks that evolve out of the meetings come from that conversation between the Sergeant and the Superintendent. Particularly that Sergeant that is in essence presenting the incidents to the Superintendent ... I mean the more information we possess, you know, the better decisions we can make in relation to actions.”

- 10.23 Inspector Padraig Dunne was at this time serving in the Waterford Division. He was the Inspector assigned to Unit D of the Waterford District (that is the unit to which Garda Murphy, Sergeant Banville and Sergeant Whelan were assigned). He gave an insight into the manner in which items from PULSE were brought to such meetings.

- 10.24 Speaking of the preparation of the list by the unit sergeant on a given day, he said that everyone had a different way of doing it. Some sergeants just printed the pulse list for the relevant time period, while others printed the first page of each incident. Inspector Dunne thought that, *"the vast majority were printing the list. If you printed off a list, you had maybe two or three pages. If you printed off the front page of the PULSE incident, it would all depend on the day, you could have 150 pages"*.
- 10.25 Inspector Dunne said that the list of incidents or the narrative would not have displayed the review screen. That screen would have to be separately accessed in order to see the GISC notification on the system.
- 10.26 As noted above, as this incident was not accessed on the PULSE system between 28th March, 2009 and June, 2010, any access to the incident prior to the meeting of 30th March, 2009 cannot have gone beyond a print of its listing on the system. Inspector Dunne agreed that, had it come to the attention of those at the meeting that GSIC had raised the query, it would have given reason for further scrutiny at the meeting.
- 10.27 Asked if every item that came up on the PULSE system for the previous 24 hours would be discussed in some way at these meetings, Inspector Dunne said that he could not say that, because an *"awful lot"* of entries under *"Attention and Complaints"* could be just *"check points"* and just were not going to be discussed. This was also because *"anything in 'Attention and Complaints' is to be a non-crime issue"*. *"Attention and Complaints"* would not be glided over but the meetings dealt with the most serious matters first and worked down the list, although the list came in all sorts of order.
- 10.28 Inspector Dunne instanced, as an example, how a member could raise with the Superintendent that they had categorised a matter under *"Attention and Complaints"* as they were not happy that it was a crime and possibly the Superintendent would say, *"let it in to me and we will see"*.
- 10.29 Speaking of the volume of matters for discussion at these meetings, Inspector Dunne said:

“[y]ou see if you don't make decisions there at that meeting there was another 50 decisions coming in the next day and another the next day and the next day and even whilst the meeting was going on there was 24 hour policing going on. So something could happen at the meeting”.

10.30 Qualifying this, he also said that:

“[f]or instance if the Sergeant made a mistake printing and forgot to print an issue just because it wasn't discussed didn't mean that it absolved people that if hadn't been discussed that people could say, ‘well, nothing came out of that and we'll leave it where it is.’”

10.31 In his evidence, Inspector Dunne highlighted the difficulties that could arise with the use of this category of *“Attention and Complaints”*. He told the Commission that, *“[i]t's probably the area that has given us the most problems in the Guards, ‘Attention and Complaints’”*. He said this was because the Crime Counting Rules were subjective at that time, in that one member might say something was a crime while he (Inspector Dunne), looking at the same set of data, might say, *“I haven't my mind made up that it is a crime”*.

10.32 Inspector Dunne said that this had caused the organisation all sorts of difficulties and as a result, the system was changed, whereby after 2009 GSIC looked at the information about an incident inputted by a member onto PULSE and decided how to categorise it; they were trained to do so. Referring to the fact that in 2009, *“it was subjective”*, Inspector Dunne said, *“‘Attention and Complaints’ was a difficult area that someone could put something into it, perhaps, that they may feel the threshold hadn't arisen for them to think it was a crime”*.

10.33 Inspector Dunne also said that in the year prior to his giving evidence, the then Waterford Division had 26,000 incidents, just short of 9,000 of which were crimes, leaving 17,000 *“Attention and Complaints”*. Of those numbers he thought that 16,000 of the 26,000 were attributable to Waterford City, 6,000 or 7,000 of those being crimes. The current figure was around 300 incidents a week in Waterford.

Weekly meeting Monday 30th March, 2009

10.34 As set out above, the incident concerning Grace was recorded on PULSE on Saturday night, 28th March, 2009. There was no meeting held in Waterford on Sunday, 29th March, 2009 and, as such, in accordance with the practice in Waterford, incidents recorded over that weekend were for discussion at the weekly meeting on Monday, 30th March, 2009.

10.35 Sergeant Banville was the unit sergeant on duty that day from 6.00 a.m. She could not recall whether she attended the meeting and had no specific recollection of bringing the incident concerning Grace to the meeting. She could not recall having any discussion with Superintendent Delaney or any Inspector in Waterford in relation to the incident. She did, however, tell the Commission about her general practice in attending those meetings:

“[a]ll I can say is when I went to the morning meeting with the list I went through every single solitary incident that was on the list no matter what category it held; every incident, whether there was 10, 20, 100 or 200. I explained what every incident was about. Regardless of its categorisation. I am 100% certain that was my practice at every meeting.”

10.36 She went on to say, *“I cannot imagine if I went to that meeting that it wasn’t discussed.”*

10.37 An entry in Superintendent Delaney’s officer’s journal recorded that he chaired the meeting on 30th March, 2009. He had developed a practice of recording the main things on which he gave direction at a particular meeting. Details of five incidents were recorded in his journal for that meeting. None of the incidents related to Grace.

10.38 Superintendent Delaney could not recall the specific meeting. However, he told the Commission that the first time he became aware of Grace’s case was a number of years later when he was contacted by the District Office in Thomastown in relation to the matter.

- 10.39 Inspector Dunne's officer's journal indicated that he was on duty that day from 9.00 a. m. to 1.00 p. m. He could not recall attending the meeting but told the Commission that the case of Grace never came to his attention and that it was never discussed with him.
- 10.40 The Commission sought the minutes of this meeting. However, neither these minutes nor any records of them were available and the Commission was advised that they had been destroyed after seven years.
- 10.41 Superintendent Delaney expressed his view to the Commission that the incident had been mis-categorised. He told the Commission he was not satisfied with the incident being categorised as "*Attention and Complaints*", explaining, "... for '*Attention and Complaints*', you know, to move into a crime it's not beyond a reasonable doubt that it occurred. It is if there is a reasonable probability. It is really a percentage call at the end of the day. You know a person arriving with bruising like that, like that needs to be explained."
- 10.42 While Superintendent Delaney was of the view that, in order to alert him, the incident should have been properly categorised from the start, he also gave evidence that he paid particular attention to incidents in the "*Attention and Complaints*" category when conducting the daily meetings, as he was often "*very suspicious*" of the use of that category. He told the Commission that, "*you know we had to be very wary of crimes being hidden within 'Attention and Complaints' category ... the obligation was certainly on us, on Superintendents, to look at an incident and say, 'why did somebody call that as a non-crime?'*"
- 10.43 Superintendent Delaney said that, as Superintendent, one had to really "*third-guess*" the situation, as a Sergeant would have perhaps helped the member put it onto PULSE, so second-guessed it, and it was for his office to look at it and say "*well, look, is there a reasonable probability that this is an 'Attention and Complaints?'*" He said that that was the standard required, it took time, and every incident varied. Superintendent Delaney said that the first person to go to would be "*the author*" and if he could not get the unit sergeant, he would have his own sergeant, Sergeant Buckley, to make an enquiry on his behalf. He said that the only way to explore such an entry was either to talk to someone about it and to explore it or to put it on the correspondence register in the District Office and ask for a written query to clarify it.

- 10.44 As reported above, Superintendent Delaney was not aware of, nor could he recall being made aware of, the incident at the time. In particular, he had no recollection of the meeting of 30th March, 2009, or of the matter being discussed at that meeting. Indeed, no one who attended that meeting and gave evidence had any recollection of the meeting or the incidents that were raised or discussed.
- 10.45 The difference between the evidence of Superintendent Delaney and Sergeant Banville as to how this matter ought to have been initially classified on PULSE was not resolved on behalf of An Garda Síochána at the Commission. The Commission is satisfied, however, that, having regard to the incident categories specified in the PULSE user manual for “*Attention and Complaints*”, a report of this nature did not fit within this category. In this regard, looking at the matter at the Commission, Sergeant Banville agreed that the required threshold for recording the incident under the “*Crime*” category on PULSE would probably have been met, but said that she categorised it at the time under “*Attention and Complaints*”, as she considered that there was, in fact, insufficient evidence of a crime having been committed. The Commission is satisfied, however, on the evidence that a member did not have to be satisfied that a crime had been committed in order to enter a matter under the “*Crime*” category on PULSE. In accordance with the Crime Counting Rules, the Commission is satisfied that the appropriate category for a report of this nature on the PULSE system was under the “*crime*” category rather than the category of “*Attention and Complaints*”.
- 10.46 It is important to emphasise that this is not a finding that Grace’s bruising was caused in a criminal manner, but rather that this category, rather than the “*Attention and Complaints*” category, was the appropriate classification for this report. In this regard, the evidence was that inclusion of the matter in this category was not dependent on an investigation to establish whether a crime had, in fact, been committed.
- 10.47 However, the lack of clarity in practice as to the classification of incidents by members of An Garda Síochána on the PULSE system (at least in Waterford, insofar as the evidence to the Commission was confined to that District) at that time was amply demonstrated in the evidence of Superintendent Delaney and of Inspector Dunne about the difficulties with the use of this category. It was

apparent from this evidence that it was not unusual for a matter, initially categorised under “*Attention and Complaints*” to have to be reclassified later following review.

10.48 Having regard to the above, the Commission considers that this matter was, in fact, mischaracterised at the outset.

10.49 The position is that if the incident was discussed at the meeting, either as a result of being raised by Superintendent Delaney, or being brought to his attention by others, no decision was made that altered the manner in which it had been classified on the PULSE system, or the manner in which it proceeded from Waterford District to Clonmel District. The Commission could not establish from the evidence provided whether or not the incident arose for discussion at the meeting.

10.50 Superintendent Delaney’s evidence in relation to his view that the file should have been transferred to Clonmel through the District offices, and thereby brought to his attention, is considered later in this Volume.

Garda Murphy’s report, 30th March, 2009

10.51 On 30th March, 2009, Garda Murphy submitted a written report on the incident to Sergeant Banville. Her report set out the following:

“Sergeant I/C

Unit D

Re PULSE Incident 5749703, Attention and Complaints

On 27/03/2009, I attended a call from [Iain] Smith, [Day Service Provider A]. [Iain] is a social work team leader for vulnerable adults, he works with the HSE. [Iain] made a report of suspicious bruising to one of the females who attends the centre daily. The female’s name is [Grace]. Her date of birth is 24th November, 1978. [Grace] has profound intellectual disabilities. [Grace] resides with [Mrs. X] [Address] [Telephone Number]. She has

done so for almost 20 years. This is a casual agreement that has continued on from when [Mrs. X] had originally fostered [Grace].

[Grace] attends the day centre Monday to Friday 9.30 to 4pm. On 27/03/2009 [Grace] arrived at the day centre as usual via the patient transport bus. She was suffering from diarrhoea and when the centre staff were washing her they noticed the bruising. Staff of the centre notified [Iain] Smith, who subsequently contacted the Gardaí. At the centre I spoke with [Ms D] (CM 2) and [Ms B] (Social Worker in the centre). [Ms D] informed me that [Grace] would have gone swimming on Tuesday or Wednesday and there had been no report of a bruising made at the time. [Ms D] contacted [Mrs. X] to explain [Grace] had not gone home on the bus as usual as staff had noticed the bruising and as a result of their concern they had notified the Gardaí. [Mrs. X] then told [Ms D] that when [Grace] had left home that morning she had no bruises.

[Grace] was taken to WRH by centre staff for a medical examination. The doctor who examined her believed her injuries may have been non-accidental and as a result of a written complaint by [Iain] Smith on [Grace's] behalf she was then taken to SATU for further examination.

An examination was carried out by Dr. Mary O'Gorman. I was present for the examination and co signed all samples taken. These will be sent off for analysis. Dr. Gorman said that the bruising present on [Grace] were more than 18-hours old. When I left the hospital, [Iain] Smith and other centre staff were discussing the next immediate steps to take in relation to [Grace's] living situation.

Garda

(Mary Murphy) [Garda Number redacted]"

Request for specialist interviewer

- 10.52 On 30th March, 2009, Sergeant Banville had the report forwarded to Garda Katherina Savage, a specialist interviewer, to see if a statement could be obtained from Grace. Sergeant Banville explained that the reason for asking the specialist interviewer to see if Grace could be interviewed was because it would have expedited matters, in that Garda Savage was based in Waterford, as was the SATU. Sergeant Banville told the Commission that if it went directly to the Village Garda Station, that station would have telephoned them and asked them to make that arrangement in any event.
- 10.53 On 31st March, 2009, Garda Savage attempted to contact Mr. Smith to arrange a strategy meeting to see if Grace could be interviewed. She telephoned Day Service Provider A and left a message which was picked up by Ms B, social worker, who passed it on that day to Mr. Smith. He subsequently contacted the Gardaí and a meeting was arranged for the following week.
- 10.54 On 7th April, 2009, Garda Savage, along with another specialist interviewer, Garda Jennifer Bourke, met with Mr. Smith in the HSE offices. A decision was made not to interview Grace because of her profound intellectual disability and as she could not communicate.

Specialist interviewer's report

- 10.55 In her report of the strategy meeting, dated 23rd April, 2009, Garda Savage set out that Grace was not a candidate for interview, and also recorded Mr. Smith's wider concerns about Grace and the Family X placement. She told the Commission that these did not necessarily concern her as a specialist interviewer, but as a Garda she had a duty to pass on information she was aware of to the investigating team and that that was what she was doing. Her report set out the following:

"Re: Request to Interview [Grace] [Address].

In relation to the above request I wish to report the following. A strategy meeting was held with Mr. [Iain] Smith, Social Worker, on 07/04/09, those present were Mr. [Iain] Smith, Garda

Katherina Savage and Garda Jenny Burke. At this meeting Mr. Smith outlined to us that [Grace] has a profound intellectual disability resulting in her having the capacity of a 9 month old baby approximately. [Grace] has no means of communication, she can not talk, use sign language, bliss board, etc., she cannot communicate when she is in pain or if she has any needs.

[Grace] is able to walk and all her behaviour is habitual, learned over the previous 30 years. The only communication [Grace] has is to grab a person arm when she requires the bathroom.

In light of the above [Grace] is not candidate for interview, either under the provision of Section 16 (1)(B) of the Criminal Evidence Act 1992 as amended or in the traditional form of taking a witness statement.

At this meeting some concerns were raised in relation to the care [Grace] is receiving where she is living. [Grace] is resident with a [Mrs. X] at the above mention address. It appears to the social work team that she does not have a designate bedroom for herself; she has missed considerable amounts of time from her day care centre at [Day Service Provider A] which have gone unexplained. She turned up at her day care centre with unaccounted for injuries in the past such as bruising to her face and has a deformity to one of her fingers, where she suffered a broken finger but did not receive any treatment for this. [Grace] would be in receipt of social welfare but clothes do not appear to be bought for [Grace], of visits to G.P. or the dentist do not have appear to be made or kept. [Grace] does not have any concept of money and would never have money herself. As far as her carers are aware, [Grace] does not have bank account or credit union account. [Mrs. X] collects her social welfare benefits.

The HSE are currently in the process of trying to move [Grace] from this accommodation as [Mrs. X] is not registered with the HSE as a carer and has not got Garda Clearance. Before this

can be achieved, [Grace] has to be made a ward of court. [Mrs. X] started to look after children with intellectual disabilities on a voluntary basis in the early 80's when she and her husband move to Ireland from England, but have never received clearance to work with children. [Mrs. X] has threatened suicide if [Grace] is taken from her alleging that she needs the income that she receives in order to live.

It has also being reported that [Mrs. X] has two males living in what has been described as outhouses on her premises, the social worker was unsure of the reason for this or if they are members of [Family X]. [Mrs. X] also failed to notify the HSE on the death of her husband and this did not come to the attention of the HSE for a number of years after [Mr. X's] death. [Mrs. X's] grandson is also resident in the house with her.

As a result of the injuries that [Grace] presented with, she was brought to the SATU in Waterford Regional Hospital and underwent an examination there. The results of this examination are pending.

In light of the above information, [Grace] is unsuitable to undergo the interview process. I would recommend a copy of this report be forwarded to [the Village] Gardaí for their information.

Forwarded for your information and attention, please.

_____ [Garda Number redacted]

(Katherina Savage)"

- 10.56 Matters referred to in Garda Savage's report, such as the deformity to one of Grace's fingers, visits to her general practitioner, Mrs. X's need for income, and the fact that two males lived within the curtilage of Mrs. X's house, are matters investigated and considered in full in the Care Volume of this report and dealt with there.

10.57 Sergeant Banville could not recall whether she ever looked for or saw Garda Savage's report. She said, *"what I can recall is that when I did make enquiries, it was that the file had gone to [the Village Garda Station] and therefore I wouldn't have looked for the file."* She thought that this may have been when Mr. Smith looked for an update on the investigation, which was on 24th June, 2009.

Forensic samples

Taking of the samples

10.58 As has been reported above, certain forensic samples were taken by Dr. Mary O'Gorman, SATU, Waterford Regional Hospital, during the course of her forensic medical examination of Grace on 27th March, 2009. These samples, together with a set of photographs taken during the course of the medical examination, were given, on the conclusion of the examination, by Dr. O'Gorman to Garda Murphy. Garda Murphy immediately placed those samples and photographs in a sealed evidence bag and took them into her custody.

Forensic samples passed to Scenes of Crime Office

10.59 In Waterford Garda Station, forensic samples requiring analysis were passed to the Scenes of Crime Office. The Commission heard evidence that the items were usually brought up to the Forensic Science Laboratory on a Tuesday each week by the Forensic Liaison Officer in the Scenes of Crime Office, Detective Garda Aidan Slattery. He would also collect items that had been tested in the Forensic Science Laboratory and return them to the station.

10.60 On 30th March, 2009 at 1.45 p.m, Garda Murphy gave the SATU examination kit (containing the forensic samples) to Detective Garda Paddy Kelly to lodge with the Scenes of Crime Office. The samples had been in her possession until that time. She said in evidence that, as far as she was aware, that was the last she saw or heard of the samples until she was asked about them in 2011. This aspect is considered further below.

10.61 Detective Garda Kelly passed the SATU examination kit to Detective Garda Donal Loughnane in the Scenes of Crime Office. Detective Garda Loughnane

made a note in his notebook of receiving the kit at 3.30 p.m. on 30th March, 2009, and that it had been placed under refrigeration. He told the Commission that there was no formal system in place to record what SATU kits were received in the Scenes of Crime Office.

Responsibility to have samples sent to laboratory

- 10.62 Detective Garda Loughnane explained that responsibility for filling out the C.56 Form (the form designated to have samples sent to the laboratory) rested with the member who had taken custody of the samples, in this case Garda Murphy, irrespective of whether that member was the reporting member or the investigating member. Detective Garda Slattery confirmed this to be the position, as did Sergeant Banville. Sergeant Banville told the Commission that she would not specifically have instructed Garda Murphy *“around the samples”*. No C.56 Form was filled out at that time.
- 10.63 The C.56 forms came in a booklet of forms which was available in the Scenes of Crime Office. Detective Garda Slattery explained that if an item came into the Scenes of Crime Office without a C.56 form, it would be left on one of their shelves or placed in the fridge.
- 10.64 The SATU kit remained, untested, in the fridge in the Scenes of Crime Office from 30th March, 2009 until 16th August, 2010, when it was moved to PEMS by Detective Garda Slattery.
- 10.65 Detective Garda Slattery said that they took in two or three SATU kits a month in the Scenes of Crime Office, maybe four at most. He said that he could put six to eight kits in the fridge in the Scenes of Crime Office and they also had a fridge in the storeroom. The fridge in the Scenes of Crime Office, where the samples were kept, was a *“Lec Medical,”* which was similar to a standard under-counter fridge.
- 10.66 The system Detective Garda Slattery operated was an *“ad-hoc”* one whereby, when the fridge was reaching capacity, he would make a list of the items in it and approach the members concerned with a view to moving the item on or disposing of it. He told the Commission that the kits did not stay very long and that they would generally go to the Forensic Science Laboratory within a week.

10.67 Detective Slattery did not recall speaking to Garda Murphy about the kit in this case but said that he would have more than likely been in contact with her to see what was happening with it, as that was his normal procedure. He explained:

“ ... I would have made some effort. I would have rang her or I would have met her in the corridor and I would have said; ‘Mary, what’s happening with this exhibit I have, this rape kit I have in the fridge? I have it for a long time now, what’s happening with it?’ She would give me some form of an answer and sometimes they would say, ‘look it, we are waiting to pick somebody up. We are waiting to get DNA from somebody else’”.

10.68 Speaking hypothetically, Detective Garda Slattery said:

“[t]here would be some excuse done. She’d say ‘just hold on to it for the moment’ and that’s what I would do.”

10.69 Garda Murphy could not recall any specific discussion with Detective Garda Slattery about the samples but did not discount the possibility that there might have been one. The Commission cannot establish on the evidence available to it as to whether or not such a conversation did in fact occur.

10.70 At the time the kit was received in the Scenes of Crime Office on 30th March, 2009, all property was required to be stored in PEMS. However, at that time, the PEMS store did not have a refrigeration facility. Detective Garda Slattery explained that that was the reason the kit had remained in the Scenes of Crime Office. Once PEMS acquired a fridge, which he thought was around August, 2010, he then lodged the kit with Garda Manning, the PEMS manager.

10.71 However, it emerged during the course of the Commission’s investigations that the PEMS store had a fridge from at least 3rd September, 2009. Detective Garda Slattery accepted that, in light of this, he should have moved the kit to the PEMS store sooner than he did. Had this occurred, the PETS reminder system could have generated 11 monthly reminders to the member responsible between 3rd September, 2009 and the date he lodged the samples with the PEMS store on 16th August, 2010.

10.72 Station audits were conducted in Waterford during this time. A Divisional audit was also conducted by the Garda internal audit section. These were routine audits. In relation to property, PULSE incidents were selected randomly and any associated property checked. The Commission is satisfied that the fact that the samples were in the Scenes of Crime Office and not PEMS would not have excluded their being captured by an audit, had the incident been one of those randomly selected.

Samples transferred to PEMS store

10.73 Detective Garda Slattery filled out a receipt for the purpose of transferring the kit to PEMS on 16th August, 2010. That information was then uploaded onto the PEMS computer system. The Garda-in-Charge was recorded as Sergeant Epsilon and the station as “[the Village] *Garda Station*”. Detective Garda Slattery could not recall where he got that information from to fill in the receipt, suggesting possibly Garda Murphy. Garda Murphy had no recollection as to whether or not this was the case.

Queries raised in 2011 with Garda Murphy regarding the samples

10.74 The samples were not ultimately sent for analysis until June, 2011 when, as part of the Garda investigation launched into the two incidents reported on 20th August, 2008 and 27th March, 2009, details of the samples’ location and status were sought.

10.75 As part of that investigation, which was undertaken by Thomastown District Office, in the Kilkenny/Carlow Division, the following queries were raised with Garda Murphy in relation to the samples taken at the SATU on 27th March, 2009:

- *Were the samples sent for forensic examination?*
- *If so what were the results?*
- *If they were not sent where are the samples now?*

- *A list of members who have had dealings with these swabs needs to be ascertained as continuity statements will have to be requested from these members;*
- *If these swabs were not analysed they will need to be transported to the forensic lab for analysis.*

10.76 Garda Murphy sent back a reply where she stated:

“[t]he swabs taken at WRH SATU were not sent for examination as there were no swabs from a SO [Suspect Offender] to compare with. The kit is currently stored at SOC [Scenes of Crime] in Waterford Garda Station. I am the member who handled the kit at WRH + I have relevant notebook entries if necessary.”

10.77 Earlier in 2009, Garda Murphy had advised her unit sergeant that the results of tests with respect to Grace conducted at the SATU had not yet been received. Reviewing this in evidence, Garda Murphy told the Commission that she had no explanation as to why she had reported to her unit sergeant in this fashion when she had not sent the samples to the Forensic Science Laboratory. Garda Murphy told the Commission that in 2009 she did not, in fact, know that the responsibility was on her to send samples from the Scenes of Crime Office in Waterford to Dublin. It was her assumption that when the investigating member was assigned, they would take over that role.

10.78 With respect to her response to the queries raised by the investigation team in 2011, Garda Murphy told the Commission that she was baffled by her response that samples would not be sent because there were no samples from a suspect for comparison, and could not explain why she had put forward this explanation at the time.

10.79 Garda Murphy was asked if she discussed the queries which had been raised with a supervisor before she wrote her reply. She said:

“I don’t think I would have. I don’t think I would have. And that’s why it – that is why I’m lost for words as to why I wrote what I

did. Because obviously if I had spoken to the supervisor on that, there is no way a supervisor would (a) have accepted what I wrote without addressing it immediately and ... well given the seriousness of the incident either, to write a reply like that and to and to handwrite a reply then it wouldn't probably have been accepted either."

- 10.80 Garda Murphy was asked if she might have telephoned or talked to somebody in An Garda Síochána about the queries raised. She said, "[n]o, I don't think who, I can't think of anyone in An Garda Síochána that I could speak to that would actually come out with such a statement and tell me to write that down."

Garda Murphy's second report

- 10.81 Sometime after Garda Savage submitted her report on 23rd April, 2009, Garda Murphy submitted a second report addressed to the "Sergeant-in-Charge Unit D". This short and undated report set out, principally, the outcome of Garda Savage's strategy meeting, namely that Grace was not a suitable candidate for interview, Garda Murphy's own view on the time and location of the occurrence of the injuries, and that the results of the tests performed at the SATU on 27th March, 2009, had not yet been received.

- 10.82 Garda Murphy's undated report, as sent, read:

"Sergeant I/C

Unit D

Re: PID 5749703. Attention and Complaints

Following concern expressed by [Iain] Smith, social worker of [Grace], that [Grace] may be the victim of an assault; Garda K Savage was requested to ascertain if [Grace], was a candidate for interview.

Following a strategy meeting, Garda Savage wrote a report in which she states [Grace], is not a candidate for interview.

It is not possible to say where or when exactly [Grace], received the bruising to her body. On the 27th March staff of [Day Service Provider A], informed me that [Grace] would have gone swimming on the Tuesday or Wednesday and that nothing had been reported at that time. The bruising was noticed on Friday morning when one of the staff was bathing [Grace].

The result of tests performed at SATU, in Waterford Regional Hospital on 27th March have not yet been received.

Forwarded for your attention, please

(MARY MURPHY) [Garda Number redacted]

GARDA”

- 10.83 Sergeant Banville told the Commission that she had never seen this report and that the first time it came to her attention was when it was sent to her by the Commission.
- 10.84 Sergeant Whelan had no recollection of receiving the report. He confirmed, however, that a handwritten note at the bottom of the report was his. The note was addressed to the Sergeant-in-Charge Waterford and read, “[p]ease find attached report of Garda Murphy. Please forward attached report to”. The rest of the sentence was missing due to the quality of the only copy of the report available to the Commission. Sergeant Whelan had no recollection of ever seeing Garda Savage’s report prior to receiving a copy from the Commission.
- 10.85 Sergeant Whelan had no recollection of speaking to Garda Murphy about this report and Garda Murphy did not recall their having any discussion about it. He told the Commission, however, that he would normally sit down with any member of the unit who provided such a report to find out what was going on with respect to it. There was no evidence of this having occurred on this occasion.
- 10.86 Sergeant Whelan said that, generally, he and Sergeant Banville had “a very good working situation” at that time as unit sergeants. He said that he was

aware of what Sergeant Banville was doing and that she was aware of what he was doing. Sergeant Whelan had no recollection of this particular incident when giving evidence and told the Commission, “... *that’s not to say I didn’t talk to Garda Murphy about it, or Sergeant Banville, I just have no recollection of it.*”

Conclusions on responsibility to send samples for analysis

- 10.87 Sergeant Banville could not recall making any enquiries of Garda Murphy in relation to the samples, although generally the report would come back to the listed member (Garda Murphy). She said, “*I was of the view that the samples had been sent to headquarters [Forensic Science Laboratory] and that [the Village Garda] were now investigating. So it wouldn’t have been, it wouldn’t have come back to us.*” The investigation, in her view, was now the responsibility of another District.
- 10.88 Sergeant Whelan’s evidence, on the other hand, was that he probably should have followed up with Garda Murphy about the samples. Any responsibility in this regard, he said, would definitely have fallen between himself and Sergeant Banville as the unit sergeants.
- 10.89 The Commission is satisfied that either Sergeant Banville or Sergeant Whelan should have followed up the status of the forensic samples with Garda Murphy. Garda Murphy was a junior member of the force at that time and required guidance, support and supervision by her superiors. The Commission considers that it is likely that, if there had been follow up on the samples, it would have been discovered that they had not been sent and that that omission could have been addressed at a much earlier stage.
- 10.90 On either account given by Garda Murphy, namely in her reply to the queries raised in 2011 or in evidence, it appears that she was not, in fact, aware that she had a responsibility to have the samples forwarded to the Forensic Science Laboratory for analysis in 2009. She was unaware of the procedures to be followed.
- 10.91 It is important to emphasise that during the period relevant to the Commission’s investigations, Garda Murphy was a probationer Garda, who carried out her duties under the supervision of unit sergeants. The responsibilities of unit

sergeants under the Garda Code required them to give special consideration, support and direction to probationer Gardaí. There was no evidence before the Commission that Garda Murphy had received any direction within her unit with respect to responsibility to forward samples taken to the Forensic Science Laboratory in the particular circumstances, where the case was to be transferred to another District for investigation and where she was not the assigned investigating member.

Incident transferred to the Village Garda Station

10.92 On 27th April, 2009, the file was transferred directly to Sergeant Epsilon in the Village to investigate. This was transferred through the office of the Sergeant-in-Charge, Waterford at the request of Sergeant Whelan. Sergeant Whelan was not on duty during the week when the alleged incident came to the attention of An Garda Síochána. He did not recall requesting the transfer of the file but accepted that this was done at his request.

10.93 In his evidence in relation to the rank at which material would pass from one District to another, Sergeant Whelan said that, generally speaking, it would be from the Garda to the sergeant of the unit and it would pass from his office to Sergeant Langton's office and be forwarded on for the attention of, *"we will say, the district office in [the Village] or to the Sergeant's office in [the Village]. So, that would ensure that somebody of rank would receive it at the far end."* As to whether it would normally go from the Superintendent in one District to the Superintendent in another, he simply said that if the Sergeant-in-Charge in Waterford sent it *via* their Superintendent's Office, it would go to the Superintendent's Office in the other District.

11. Communication between Districts

The transfer of a matter reported in one District to a different District for investigation

Preliminary

11.1 Much turned in the evidence before the Commission on the manner in which each incident was transferred from Waterford station for investigation.

- 11.2 The manner of this transfer was of considerable importance as, in each case, it resulted in both incidents being transferred from Waterford to the Village Sub-District, without coming to the attention of any Senior Officer in Clonmel District.
- 11.3 As reported above, there was a distinction between the manner of transfer of the August, 2008 incident and that of March, 2009. The August, 2008 incident was transferred at Sergeant level in Waterford to the Sergeant-in-Charge in Clonmel Station which was the location of the District Office (Sergeant O'Dwyer's evidence that he was Sergeant-in-Charge of Clonmel Sub-District, rather than of the entire District, has been addressed above). The March, 2009 incident was transferred at Sergeant level in Waterford directly to the Village Sub-District, that is, to Sergeant Epsilon's station.
- 11.4 This resulted in a situation where there was no record in the District Office in Clonmel of the files in respect of either incident having been sent to the the Village Garda Station for Sergeant Epsilon's attention. The circumstances giving rise to the lack of communication between Sergeant Epsilon and the District Office in Clonmel with respect to these matters are considered below.
- 11.5 The evidence received at the Commission from senior officers of An Garda Síochána on the matter of such transfers, predominately related to the manner of the transfer of the March, 2009 incident.
- 11.6 This evidence was closely tied into the issue as to how the March, 2009 incident had been entered on the PULSE system, in particular its categorisation under "*Attention and Complaints*". This, in turn, was closely tied into the evidence about how an incident so classified might have been viewed at the meeting at Waterford Garda Station on 30th March, 2009.
- 11.7 The issue for the Commission with regard to the transfer of an incident reported in one District for investigation in another District was whether there was a clearly prescribed manner at the time for any such transfers between Districts within An Garda Síochána and, if so, whether this was clearly implemented in Waterford.

- 11.8 As set out earlier, the provisions of Chapter 47.13 (1) of the Garda Code, in operation at the relevant time, provided for intercommunications between stations as follows:

"As a general rule, communications between Stations in different Districts should pass through the District Office. Members-in-Charge of Stations may, however, communicate with one another directly by phone or otherwise in respect of urgent matters such as absconding offenders or any matter of routine nature."

- 11.9 The Garda Code did not make specific provision with respect to the transfer of a matter between Districts which was reported to An Garda Síochána in one District but for investigation in another District. Matters covered by *"any matter of routine nature"* were not set out in the Code.

- 11.10 Having regard to the manner in which each incident was transferred for investigation from Waterford, it is evident that, as a matter of fact, the transfers were treated as communications of a routine nature.

The evidence of senior officers on the issue of transfer

- 11.11 The Commission received evidence, however, from two senior officers of An Garda Síochána that the transfer of the March, 2009 incident from Waterford District to Clonmel District, should have been transferred at District Office level. Such evidence was given by Superintendent Delaney and Superintendent Dolan, who were the respective Superintendents in Waterford and Clonmel at the time.

Superintendent Delaney

- 11.12 In his evidence on the issue, Superintendent Delaney said that, *"I would say in a case like this ... in my view, should have gone from District to District."*
- 11.13 He went on to say, *"[s]o, what I'm saying is that a case which has evolved into a significant case like this should have gone from one [superintendent's] office to another ... That's my view."*

- 11.14 Superintendent Delaney also said that *“ideally this case should have been transferred from Superintendent to Superintendent level”*.
- 11.15 Superintendent Delaney’s view that the case should have been transferred at District Office level was substantially based on his considerations, retrospectively at the Commission, as to how this particular incident should have been approached, had it come to his attention at the meeting of 30th March, 2009. As reported above, Superintendent Delaney did not recall the meeting and had not heard of Grace’s case before 2011, and there was no record of the incident having been discussed at that meeting.
- 11.16 Superintendent Delaney instanced a number of steps that might have been taken had this *“Attention and Complaints”* matter received attention at the meeting of 30th March, 2009. This related to his evidence about the need to review and query matters classified as *“Attention and Complaints”* generally, as referred to earlier in this Volume. These steps might have included, for instance, discussion as to whether any statements were to be taken in Waterford and consideration of the correct location for the incident. He said:

“...clearly you have to flesh out what is alleged here. Which station is going to take the primacy to investigate it. You would have to make reference on it. Probably somewhere either in the narrative or in the comments box to that effect. So, you know, this may have initially -- obviously this was reported in [Day Service Provider A] because [Grace] was discovered in [Day Service Provider A]. But you need to flesh out the facts to find out; well, where is the most likely place that this occurred. As which are consistent with the Crime Counting Rules. You know where is it reasonably likely to assume that this case occurred. Taking all the facts into account. But there needed be a parallel collation of what was being done on the ground with the investigative steps, i.e., taking statements and assessing the medical report and then finally updating this. Now, that decision making process should have involved me. It should have.”

11.17 In this regard, and looking at matters retrospectively, Superintendent Delaney said that in the *“perfect scenario”*, the *“Superintendents would have met and fleshed this whole matter out, as I am doing now.”*

11.18 Later, he said that the next step in April, 2009:

“... was for people to communicate between Districts, between Superintendents, perhaps involve an Inspector or Detective Inspector or people involved in basically working through these type of cases from the start. So that, in my view, was the perfect way of dealing with this case.”

11.19 This evidence of what might happen in a *“perfect scenario”* was an assessment from a vantage point some years later. This is not intended as a criticism of Superintendent Delaney, who was giving his view retrospectively about the *“perfect way of dealing with the case”*.

11.20 It is clearly not possible for the Commission to make findings of fact as to what, if any, steps may have been taken, had the item been the focus of any attention at the meeting of 30th March, 2009.

11.21 The Commission heard evidence that more serious matters under crime categories on PULSE were generally prioritised for attention at meetings, but that every item would be reviewed. Superintendent Delaney agreed that the fact that the incident was categorised as *“Attention and Complaints”* may potentially have contributed to its being overlooked.

11.22 Even taking account of the factors of subjectivity and *“percentage call”* when inputting an incident as *“Attention and Complaints”*, the Commission accepts the evidence that, having regard to the Crime Counting Rules, the matter was miscategorised at the outset. The GISC alert system’s core function was to assist An Garda Síochána in such circumstances. Unfortunately this review did not occur and the incident was not re-categorised until an investigation commenced in 2011.

- 11.23 Whether the fact that this was an item under “*Attention and Complaints*” that was to be transferred to another District from the outset had any impact on how much attention it received at the meeting, can only be a matter of speculation.
- 11.24 In the absence of any evidence of discussion of this “*Attention and Complaints*” item at that meeting, much less any note that it was a matter for transfer through the District Office, the Commission finds that it was transferred as a matter of a routine nature from Sergeant Whelan to the Sergeant-in-Charge of the Sub-District where the matter was to be investigated.
- 11.25 The Commission is satisfied that Superintendent Delaney’s view as to how this matter should have been transferred from Waterford District to Clonmel District, from one Division to another, is the correct one. The Commission is also satisfied, however, that that is dependent on the retrospective analysis as to how the matter might have been treated had it come to his attention at the meeting. In the event, there was no evidence of any discussion or steps to be taken decided upon at the meeting.
- 11.26 When the matter came to Sergeant Whelan, he transferred it as requested. The Commission does not consider that he acted incorrectly in doing so in the circumstances. In particular, the Commission is not satisfied that the reference to any matter of “*routine nature*” was defined anywhere so as to exclude a transfer of this nature.
- 11.27 Superintendent Delaney agreed with the evidence given to the Commission by Sergeant Langton, who he said was “*absolutely right*” in his evidence to the effect that the role and responsibilities of Sergeant-in-Charge were very ill-defined in the Garda Code. The Commission is satisfied that this is the case.

Superintendent Dolan

- 11.28 Superintendent Dolan had not seen any of the PULSE material until it was sent to him by the Commission. His evidence as to how the matters should have been transferred from Waterford District to his District was initially and erroneously grounded on his view of the PULSE material as updated in 2011 rather than the initial PULSE entry from 2009.

11.29 As set out above, Superintendent Dolan told the Commission that where a report of an incident that had not been recorded on PULSE was transferred from another Division into his District, he would have expected that to have been brought to his attention by the Sergeant-in-Charge in Clonmel *“who saw the correspondence going through...”*

11.30 He went on to say:

“but prior to that, I would have expected it, an incident of that nature to have gone vertical in Waterford and across to me on a District Officer to District Officer because to my mind and from my previous experience an incident like that, that is described like that, had red flags all over it.”

11.31 Superintendent Dolan’s evidence on what he meant by *“described like that”* was grounded on his view of the updated PULSE screen entry of 2011. He referred to words that appeared on that screen like *“sexual assault”, “mental capacity”, “HSE”* and said that *“[a]ll of those things would raise alarms.”*

11.32 In fact, the relevant PULSE entry at the time of the transfer in March, 2009 read:

“Iain Smith reports suspicious bruising to [Grace]. [Grace] attends [Day Service Provider A] [Address]. Female was subsequently taken to WRH and examined by doctor and SATU unit.”

11.33 Looking at this narrative in the course of his evidence, Superintendent Dolan said that had he *“read that narrative, even as an ‘Attention and Complaints’, there were enough red flags in it to warrant attention.”* Superintendent Dolan told the Commission that he thought that, *“it should have gone up the line in Waterford because of the nature of the narrative in the PULSE incident itself, that should have brought it to somebody’s attention that this has to be ‘red flagged’ in Waterford.”*

11.34 The Commission is satisfied that Superintendent Dolan's view was that the nature of a reported incident was a factor in determining how a matter was to be transferred from one District to another District for investigation.

11.35 Superintendent Dolan accepted as correct the following proposition put to him by Counsel for Sergeant Epsilon, namely:

" ... had the matter been investigated in Waterford at that early stage, beyond Garda Sergeant level, and had the file been transferred ... to your District it would have been transferred to Clonmel ... and directly to you therefore".

11.36 In this regard, he agreed that the manner in which the file was transferred from Waterford had sent matters off on the wrong course.

11.37 The Commission considers that it is reasonably likely, although by no means certain on the evidence, that, had the March, 2009 incident not been inputted in the *"Attention and Complaints"* category, or had its classification been reviewed following the GISC alert, or had the entry as listed received any scrutiny at or arising from the meeting of 30th March, 2009, the matter would have been transferred at District Office level rather than directly to the station in the Village Sub-District.

11.38 Had this occurred, it is reasonable to conclude that, in all likelihood, there would have been some investigation into the matter at an earlier stage. The nature and extent of this can only be a matter of speculation.

11.39 Noting that *"hindsight is perfect"*, Superintendent Dolan said that there were issues that could have been investigated at the time. He said that, *"[i]n the perfect world"*, if an investigation had been set up, certain steps would have been taken.

11.40 Asked what he would have done, Superintendent Dolan thought that:

"[w]ell, I would set up an investigation team to deal with it...Well, I would try to collect all the facts by using a Detective Sergeant and the assistance that he required. I would have used Sergeant

[Epsilon] for background information in relation to the family. He is a Sergeant in that area so he would have knowledge of the area. Because of the complexity of it, I would have maintained probably a supervisory role, a hands-on approach to that myself in relation to an investigation like that in the Sub-District there. So, it is so rare and so unusual that it warranted to my mind, and hindsight, as we all know is perfect, but now this warranted a full scale investigation at the time. Whether or not an assault or a sexual assault took place, at least if there was a full detailed investigation done at the time, some questions could have been answered”.

11.41 The Commission’s findings with respect to Grace’s care and the management of her case within the HSE over this period is also reported upon in both Volume 1 and the Care Volume.

11.42 The safeguards that a transfer at District Office level provided were encapsulated in the evidence given to the Commission by Superintendent Delaney, as follows:

“[y]es. Well I suppose the first thing is that you are dealing from Superintendent to Superintendent who are people who are the responsible people in a District to manage their crime. So you are handing it to the person who the Code said is responsible in essence to do their job, you know, within a District. But also you have the factor that you are sending it through somebody who is in the top position of authority within the District. They operate a system where they have probably a Correspondence Register and they can put this on a reminder system. So once it gets to a Superintendent’s office, the Superintendent can ask his clerk, ‘put that on a reminder please every six weeks’, so they can get an update report on it. So once it requires -- well once it has been deemed to be that important between Districts you have the communication starts between the two Superintendents. Eventually one of the Superintendents will agree or concur that this should be, this should remain here. ‘This is my case. Let’s do it’. Also as well, the impetus from the Superintendent will be

stronger because clearly he controls his Inspectors and his Sergeants and his Guards. So when you are asked to do something from the Superintendent's office, you know you have to do it. So, in essence, it adds that status to it. You have to perform. It can be backed up by way of reminders or whatever else, but at the end of the day the person who receives it to investigate it, you know, they generally get their act in order and do it."

Findings on transfer issue

11.43 The Commission is not satisfied on the above evidence that there was in fact a clearly prescribed and generally applied procedure for the transfer of incidents reported in one District for investigation in another District within An Garda Síochána. The evidence to the Commission, as reported above, supports a conclusion that, in reality, much depended on the view taken of the particular incident under consideration in the transferring station, in this case Waterford Garda Station. In the circumstances of this case, the Commission is satisfied that this led to a situation where, unless a specific decision was taken in Waterford that the District Office there was to be responsible for the transfer of a particular incident for investigation to a District Office in another Division, a transfer at that level did not routinely occur.

11.44 It is important to state that it was entirely clear from the evidence received at the Commission on this matter that a District Office to District Office transfer was the appropriate way to effect such a transfer (in any case), for all the reasons highlighted in the evidence considered above. The Commission is satisfied that the absence of any clearly communicated protocol to address this issue clearly contributed to the circumstances whereby these matters were transferred as matters of a routine nature.

Receipt of file by Sergeant Epsilon in the Village in April, 2009

11.45 Sergeant Epsilon received the file around the end of April, 2009. This comprised Mr. Smith's statement, Garda Murphy's 30th March, 2009 report, and Garda Savage's 23rd April, 2009 report. He could not recall seeing Garda

Murphy's undated report but told the Commission that it may well have been included in what he received.

- 11.46 Although he attended weekly meetings with the District Officer in Clonmel and subsequently Thomastown, Sergeant Epsilon did not bring this file to his superior officers' attention. He did not commence or carry out any investigation in relation to the matters outlined in Garda Murphy's report. He did have a number of discussions with Mr. Smith. These are referred to below. Sergeant Epsilon did not make any inquiries to follow up on the forensic samples, the SATU report or any potential witnesses mentioned in the reports he received. He did not record the receipt of this correspondence, or any other correspondence he received in Grace's case in the station correspondence register.
- 11.47 Sergeant Epsilon took responsibility for these failings at the Commission. Looking back on matters in the course of his evidence and with the benefit of hindsight, Sergeant Epsilon said that he should have brought these matters to the attention of his superiors and sought assistance. The Commission heard evidence that, at the time, Sergeant Epsilon was experiencing some personal problems and that matters came to a head in 2010. The Commission is satisfied on the evidence received that this was a significant factor that negatively impacted Sergeant Epsilon's capacity to deal with this matter at the time.
- 11.48 Superintendent Dolan told the Commission that he considered that the first thing Sergeant Epsilon should have done when he received the file was to ask for help. He said that once it arrived on Sergeant Epsilon's desk, in whatever way it arrived, it should have been given to him as Superintendent. Looking at the matter at the Commission, Superintendent Dolan said that this struck him as a complicated and difficult investigation. He said that assistance would have been available from the Detective Unit in Clonmel.
- 11.49 Superintendent Dolan told the Commission that, in his opinion, Sergeant Epsilon was not equipped to deal with this report. He considered that Sergeant Epsilon's *"experience, his general service in the police would not have equipped him to deal with this."* Superintendent Dolan thought that the investigation would be complex and that, had the matter come to his attention, he would have appointed a detective sergeant to lead the investigation. To his

mind, an investigation would have required crime conferences *“that are run of the mill for serious investigations”*, involving all the necessary officers and expertise, *“to push it forward”*.

12. SATU Practices

- 12.1 Two aspects of the practice in the SATU in Waterford Regional Hospital at this time arose for consideration by the Commission. First, the SATU had the benefit of an Advisory Group that met on a quarterly basis. The members of this Group included medical, nursing and administrative staff in the hospital, a local medical general practitioner, and a representative from the Waterford Rape and Sexual Abuse Centre and from An Garda Síochána. In 2009, Inspector John Mulligan was the representative of An Garda Síochána. He had succeeded Superintendent Delaney on the Advisory Group on Superintendent Delaney’s promotion to that rank.
- 12.2 The Group’s function was to assist and provide guidance to the SATU in the proper running of the unit and in the application of best practice. It did not have a clinical role and it was not part of its function to manage individual cases.
- 12.3 At a quarterly meeting of the Advisory Group held on 12th May, 2009, Grace’s attendance at the SATU on 29th March, 2009 was raised, arising from concerns expressed by the volunteer / support person who had attended there with Grace. These concerns involved Grace’s inability to communicate and verbalise her needs, and her home / living arrangements. These concerns had been expressed to Ms Agnes Cooney Lee, then Clinical Nurse Manager in the SATU, prior to the meeting. As a result, Ms Cooney Lee had contacted the social worker in Grace’s case (Mr. Smith), who, as described in the minutes of this meeting, told Ms Cooney Lee that *“he was handling all our concerns.”*
- 12.4 Inspector Mulligan was unable to attend that meeting of the Advisory Group, but accepted in evidence that he had received the minutes of the meeting. The minutes did not mention either Grace or her social worker by name. Nor did they mention where Grace’s home was.
- 12.5 An issue arose before the Commission as to whether the content of those minutes placed any individual obligation on Inspector Mulligan to check the

PULSE entry or to “*check in*” with the investigating member of An Garda Síochána to see “*if anything could be added to the investigation.*” When this was suggested to Superintendent Delaney, he replied:

“[y]es, that would be best practice, certainly it would. So whether it was told verbally to somebody or whether they got it in the minutes, you know, you would try your best to make sure that everything was done properly.”

12.6 Inspector Mulligan did not agree with this view. In evidence, he said that his role on the Advisory Group did not involve any investigative responsibility. While he had no recollection of these particular minutes or their content, he pointed out that his practice, during his membership of the Group, should a particular case be brought to his attention by a member of the Group, was to advise that person to contact the relevant Superintendent of An Garda Síochána with those concerns. He said that it was not his practice to discuss any Garda investigation.

12.7 The Commission accepts Inspector Mulligan’s evidence on this issue, and does not believe, in all the circumstances, that there was any onus on him to make any of the inquiries, as suggested.

12.8 The second matter that arose for consideration, was that insofar as the procedures in the SATU for the provision of medical reports to An Garda Síochána were concerned, in respect of an examination carried out prior to July, 2010, a report was sent to the investigating Garda upon request from An Garda Síochána. Any report in respect of an examination carried out after July, 2010 was sent automatically to An Garda Síochána without a specific request.

Mr. Smith visits Waterford Garda Station on 24th June, 2009

12.9 On 24th June, 2009 Mr. Smith visited Waterford Garda Station. His note of this visit recorded that Sergeant Banville told him that Grace’s file had gone to the Village for follow-up. In his evidence to the Commission, Mr. Smith said that he also discussed the offence of reckless endangerment in relation to the HSE and its staff with Sergeant Banville.

12.10 Sergeant Banville recalled Mr. Smith's visit. She was unsure exactly when it occurred. She said that it was a casual conversation rather than a formal or arranged meeting, and thought that she might even have met Mr. Smith going up or down the stairs. She told the Commission that she remembered a general discussion with Mr. Smith concerning what was being investigated and what actual crime, if any, might have been committed. She said that she remembered that Mr. Smith was putting "*a lot of scenarios around what exactly we were dealing with*" and what may, or may not have happened.

12.11 When asked at the Commission whether she had a memory of Mr. Smith raising the offence of reckless endangerment, Sergeant Banville said, "[i]t's quite possible that he did. I can't say that he didn't or that he did." The only clear memory Sergeant Banville said that she had in relation to the meeting, was discussing how the injuries might have occurred, and that Grace "*had a tendency sometimes*" to hit her head off the window of the bus. In relation to the file's going to the Village, she said, "*well if he asked me I would have checked and I would have told him.*"

Communications between Sergeant Epsilon and the HSE

12.12 From receipt of the file at the end of April, 2009, up to his retirement from An Garda Síochána on 25th November, 2010, Sergeant Epsilon and the Village Garda Station received a number of communications in relation to this incident. Sergeant Epsilon spoke with Mr. Smith on at least four occasions over this time. Sergeant Epsilon did not make any notes in relation to these communications. He did not discuss these with his superiors.

13. The HSE remove Grace from her home with Mrs. X – July, 2009

Grace is removed

13.1 Approximately three months after the file was sent to Sergeant Epsilon, on 17th July, 2009 the HSE moved Grace from her home with Mrs. X. The management of Grace's case within the HSE and the decisions taken by the HSE which resulted in Grace's being moved on that date are fully reported in Volume 1.

13.2 Sergeant Epsilon was not contacted by any representative of the HSE between the date he received the file in April, 2009 and 17th July, 2009.

13.3 The Commission is satisfied that the decision to remove Grace was not, in fact, dependent on any inquiry to be carried out by An Garda Síochána.

HSE solicitor contacts the Village Station – July, 2009

13.4 On 17th July, 2009, Mr. Graham Farrell, solicitor for the HSE, telephoned the Village Garda Station in relation to the HSE's removal of Grace from Mrs. X's that day. He made a note of that call on 28th July, 2009 where he recorded that he had spoken to a member of An Garda Síochána, informed him "*of the position*", which was that the HSE was moving Grace and that she was not going to be brought home to Mrs. X that day. He left a message for Sergeant Epsilon to telephone him. Mr. Farrell made a note that Sergeant Epsilon did not do so. Mr. Farrell did not recall the content of the call to the station but told the Commission that he thought that he would have given a little bit of background as to why he was ringing. Mr. Farrell told the Commission that this was the only telephone call that he made to An Garda Síochána in respect of Grace's case.

13.5 The Garda who was stationed in the Village Garda Station with Sergeant Epsilon had no recollection of Mr. Farrell's call when giving evidence to the Commission. He said that when he received a message for Sergeant Epsilon, his normal practice was to pass it on or take a written note of it and leave it on Sergeant Epsilon's desk. Sergeant Epsilon, when giving evidence, said that he could not honestly recall if that Garda had passed a message to him that a solicitor had telephoned looking for him.

13.6 Insofar as personal contact with Mr. Farrell was concerned, Sergeant Epsilon was quite definite in his evidence that he had never spoken with any solicitor for the HSE in Grace's case. Indeed, both Sergeant Epsilon and Mr. Farrell were in agreement in their evidence that they had not spoken to each other following Mr. Farrell's call or, indeed, at any stage.

13.7 Some doubt was cast on that evidence, however, by a note which Mr. Smith made of a telephone conversation which he had with Sergeant Epsilon on 13th October, 2009, referred to below.

- 13.8 On 13th October, 2009, Mr. Smith telephoned Sergeant Epsilon in relation to the incident. He made a note of the call. Apart from the note, Mr. Smith did not have an independent recollection of this telephone call when giving his evidence at the Commission. Sergeant Epsilon also did not have a recollection of the call. Mr. Smith's note set out the following:

"[Grace]

13th October

Telephone call to Sergeant [Epsilon], [the Village] Gardaí.

I rang Sergeant [Epsilon] in relation to the complaint I made in regard to [Grace]. He told me that he understood that [Grace] was now out of [Family X's] and was now in Health Service Executive accommodation.

He said 'they have taken her into care'.

[Sergeant Epsilon] said that he had been involved at the time as the solicitor for the Health Service Executive had been on the phone to him to discuss [Grace's] being moved from the day service to [her new residence].

[Sergeant Epsilon] had strongly recommended that [Grace] not be removed from the house.

I discussed the reason for my complaint and he said that he was aware that [Grace] might have been injured being lifted out of bed or into the bath. I said that [Grace] was fully ambulant and did not need lifting. He said that he was unaware of the further concerns regarding [Grace]. He said that [Grace] could not be interviewed which meant that the case could not really proceed.

I said that I had been concerned at [Mrs. X's] inconsistent explanations and [Sergeant Epsilon] said that she was elderly

and may be therefore confused. I said that she did not appear to be confused to me.

I described [Grace's] presentation at [her new residence] in relation to the incident in the bedroom and I said that this had echoes of an early referral in 1991. [Sergeant Epsilon] said that he had no knowledge of this. He was very concerned. [Sergeant Epsilon] said that he thought that I better come in and discuss this with him. We arranged to meet on Monday afternoon in [the Village Garda Station] at 2:00 p.m. (19th).

Iain Smith"

- 13.9 The above reference to Grace's presentation after her move has been investigated and considered in full, in the context of the management of her care by the HSE, in the Care Volume. Insofar as the reference to "*an early referral in 1991*" was concerned, Mr. Smith told the Commission that that was to Z.Z. Mr. Smith's communications with Mrs. Z about her daughter, Z.Z., are reported on in Part 1 of Volume 1.
- 13.10 Sergeant Epsilon took issue with the content of the note that referred to the HSE's solicitor as having been on the telephone to him to discuss Grace's move. Sergeant Epsilon said that this note was not correct and that he had had no such telephone call with the HSE solicitor.
- 13.11 The Commission is satisfied on the evidence of Sergeant Epsilon and Mr. Farrell that such conversation did not occur. Having regard to the fact that neither Mr. Smith nor Sergeant Epsilon could remember their conversation in October, 2009 at this stage, it can only be a matter of speculation as to how this difference arose. The fact that Mr. Farrell had contacted the Village Garda Station on 17th July, 2009 (although he did not succeed in speaking with Sergeant Epsilon) may somehow have become conflated into an understanding that it was to Sergeant Epsilon that Mr. Farrell had spoken.
- 13.12 The Commission considers that it is reasonable to conclude that some confusion or misunderstanding arose in this instance. No particular issue of

concern arises from the conflict between Mr. Smith's note and the evidence on this matter.

- 13.13 Sergeant Epsilon said that he may well have said Grace had been "*taken into care*" but would not have known if Grace was in HSE accommodation. He told the Commission that he would have known by the end of July or early August, 2009 that Grace was not in the Village any longer. Sergeant Epsilon was unable to remember where he learnt this, but recalled that, at that stage, he had not seen Grace's bus for a while.
- 13.14 As regards the reference in the note to Sergeant Epsilon's saying that he was aware that Grace might have been injured when being lifted out of bed or into the bath, Sergeant Epsilon told the Commission that he "*may well have said something like that, all right: did she get a fall? did she fall in the bath or fall getting into the bed or fall in the house somewhere along the line.*" Sergeant Epsilon said that he was not aware that anything like that had happened, and that this was "*just speculation*" on his part.
- 13.15 Sergeant Epsilon took issue before the Commission with the accuracy of another aspect of Mr. Smith's note which stated that he "*had strongly recommended that [Grace] not be removed from the house*". Sergeant Epsilon was adamant in his evidence that if Grace was removed from the house it was a matter for the Health Services. He reiterated to the Commission that he "*didn't recommend it to anybody, I would not. Why would I say something like that.*"
- 13.16 Although he could not really recall the conversation, Mr. Smith said that Sergeant Epsilon had said that he was not aware of any reasons why Grace should be moved or "*taken into care*". Looking at his note, Mr. Smith thought that he then told Sergeant Epsilon why the HSE had moved Grace. Mr. Smith qualified what he had stated by saying that Sergeant Epsilon had perhaps felt "*on a human level that removing someone from their home is not the right thing to do unless you have some really good reason to do it*".
- 13.17 The Commission is satisfied that Sergeant Epsilon's evidence is correct on this matter and that Mr. Smith's note does not convey an accurate representation of what Sergeant Epsilon said on this aspect in this telephone call, and that

Sergeant Epsilon did not make any recommendation in 2009 to the HSE solicitor or anyone else that Grace not be moved by the HSE.

- 13.18 With respect to Mr. Smith's note that Sergeant Epsilon had "*said that [Grace] could not be interviewed which meant that the case could not really proceed*", Sergeant Epsilon told the Commission:

"I wouldn't have said that, I wouldn't have said she couldn't proceed, like, she would be the material witness in the case. She was non-communicative as such but I doubt if I would have said that, not to really proceed."

- 13.19 Sergeant Epsilon said that this would not hold up an investigation, and that "*if there were forensic samples and there was forensic evidence in the matter, surely it would have proceeded on them lines*".

- 13.20 The Commission is not satisfied on the evidence that Sergeant Epsilon went further than to highlight the fact that Grace could not be interviewed. As observed by Mr. Smith in evidence, Sergeant Epsilon was, of course, right in that. Grace's profound disabilities precluded the possibility of so doing. This was recognised by Garda Savage in her reports.

Meeting between Sergeant Epsilon and Mr. Smith – 19th October, 2009

- 13.21 Following the telephone call on 13th October, 2009, Mr. Smith met with Sergeant Epsilon in the Village Garda Station on 19th October, 2009. His note of that meeting recorded that they spent some time discussing the background to Mr. Smith's Garda complaint earlier in the year and how he went through his concerns for Grace, in terms of sexual, physical, emotional, and financial abuse, and neglect, with Sergeant Epsilon. His note concluded that he told Sergeant Epsilon that while Grace was now in more appropriate accommodation, she had the right for any criminal acts against her to be investigated.

- 13.22 Mr. Smith recorded that they had discussed certain previous allegations and also what he described as the "*set-up*" at Family X's and Family X's relationship with the South Eastern Health Board.

- 13.23 Mr. Smith explained in his evidence to the Commission that he was using this discussion as an opportunity to ask if Sergeant Epsilon knew who was living in the house. He told the Commission that the information volunteered to him “*was obviously of great interest*” to him.
- 13.24 Sergeant Epsilon appeared to have no concerns about Alpha, whom he described as a hard worker.
- 13.25 Sergeant Epsilon said that he had not been aware of all the concerns in the case, as communicated to him by Mr. Smith, and that he said that he would revert back to his Superintendent.
- 13.26 In his evidence to the Commission, Mr. Smith recalled that he had a fairly relaxed discussion with Sergeant Epsilon and that they were not under any time constraints, so were able to get through as much as they wanted to. He said that he would have given a broad view of the background of the case because he was not “*constrained as much ... in talking to a Garda Sergeant as I might be in talking to some other service providers or other professionals*”.
- 13.27 Mr. Smith said that he felt reassured that he had Sergeant Epsilon’s attention and that Sergeant Epsilon “*would be taking the matter forwards*”. Mr. Smith said, “*I think he got to the point where he was thinking that this is going to need attention of the Superintendent and a much more detailed look by the Gardaí, and perhaps not something that he could start out on his own.*”
- 13.28 Sergeant Epsilon remembered this meeting. He recalled that they spoke about the matters outlined by Mr. Smith, such as bruising to Grace, and he was sure that they would have spoken in general terms about Mr. Smith’s views on “*sexual, physical, emotional, financial abuse and neglect*”. Sergeant Epsilon could not recollect the specifics of the conversation or discussion about previous allegations. He confirmed that while he might well have told Mr. Smith that he would revert to his Superintendent, he did not actually do that.
- 13.29 Mr. Smith had further contact with Sergeant Epsilon on 6th and 27th January, 2010. On 6th January, Mr. Smith recorded that Sergeant Epsilon indicated that his investigations concerning Grace were proceeding and that he had made several further inquiries. He also recorded that Sergeant Epsilon had a good

enough relationship with Beta to ask him a little about his background. That day Mr. Smith wrote to Sergeant Epsilon enquiring about Beta. He indicated that the HSE did not have any file information on Beta and requested that Sergeant Epsilon meet with Beta to ascertain details of his background.

13.30 On 27th January, 2010, Mr. Smith recorded that Sergeant Epsilon had met with Beta the previous night. He set out that Beta was able to give Sergeant Epsilon a clear and detailed account of his personal history, and from that it appeared that he would not meet the criteria for being a vulnerable adult. He noted that Sergeant Epsilon had described Beta as '*bright enough*' and told him that Beta had been gainfully employed without any problems since he came to Ireland. Mr. Smith set out extensive background information that Sergeant Epsilon had obtained for him. This included details of Beta's early life and origins, his arrival in the Village, and the circumstances of his coming to live with Family X. Sergeant Epsilon provided details of Beta's work life and some details of his domestic life living with Family X. Sergeant Epsilon told him that Beta was well regarded locally and was active in sport locally.

13.31 On 23rd July, 2010, Mr. Smith wrote a letter to Sergeant Epsilon seeking an update on the status of the investigation. There was no response to this letter. Sergeant Epsilon could not recall receiving it and thought that he might have been on leave at the time.

14. The SATU report

14.1 Sergeant Epsilon did not receive the SATU report with respect to Grace until it was forwarded to him from Waterford Garda Station in late September, 2010 by Sergeant Whelan. As set out above, Sergeant Epsilon had not made any inquiries to obtain this report before then. Sergeant Epsilon said that he read the report but did not do anything further as a result.

14.2 On 6th September, 2010, Ms Agnes Cooney Lee, Acting Clinical Nurse Manager, SATU, sent Dr O'Gorman's SATU Report on Grace to Waterford Garda Station, addressed to the Superintendent. The report was dated 26th August, 2010. Relevant extracts are set out in the Appendix to this report.

- 14.3 As reported earlier in this Volume, insofar as the procedures in the SATU for the provision of medical reports to An Garda Síochána were concerned, in respect of an examination that was carried out prior to July, 2010, a report was sent to the investigating Garda upon request from An Garda Síochána. Any report in respect of an examination carried out after July, 2010 was sent automatically to An Garda Síochána without a specific request.
- 14.4 As is evident from the date (26th August, 2010) the report in Grace's case was not prepared until 17 months after Grace's attendance at Waterford Regional Hospital.
- 14.5 Dr. O'Gorman did not remember the circumstances of preparing this report at the stage of giving evidence to the Commission. She told the Commission that the request for her SATU report would have come through the Manager of the SATU. Dr. O'Gorman said that the practice was that she would issue the report to the SATU Unit and that the unit would then forward it under registered post to the Garda requesting it. Dr. O'Gorman said that she would not have known the name of the particular Garda who requested a report.
- 14.6 The typed report was signed by Dr. O'Gorman. She said that, once the request came from the Gardaí to send a report, she usually typed it from the handwritten notes she had made during the examination.
- 14.7 The Commission received evidence that it is likely that Dr. O'Gorman was asked by the administrative staff in the SATU to prepare the report arising from a request for information in relation to Grace's attendance and examination at the SATU, received from Ms B, as Grace's Committee in March, 2010, and from Mr. Smith and Mr. Maley of the HSE in July, 2010, on foot of advice received from An Garda Síochána that, in the circumstances, the prepared report should be sent to An Garda Síochána, who would deal with any third party requests.
- 14.8 Superintendent Delaney told the Commission that the first time he saw the SATU report "*was a number of years after*". He explained that SATU reports were dealt with by Sergeant Buckley, who would forward them on to the member concerned. Sergeant Buckley confirmed that this was the position and

that he would have sent the reports out to the units of the member(s) mentioned in the reports, and would not have read them first.

14.9 On 13th September, 2010, the Sergeant-in-Charge, Unit D, who was Sergeant Shay Keevans, sent the report to Garda Murphy with a minute on it asking her to *“attach to main file and report in early course.”* He said that he followed up on this with Garda Murphy and she told him that the case was being investigated by Sergeant Epsilon in the Village. He instructed her to return the report so that it could be forwarded to the Village, and this was done.

14.10 Sergeant Keevans said that he would have read the SATU report. He did not speak to Garda Murphy about the samples referenced in the report and she did not mention anything about them. He told her to re-direct the report. In relation to the samples, he said that it was 18 months previously, and he *“would have expected that all that was done”*.

14.11 Garda Murphy did not remember receiving the SATU report coming to her in September, 2010. She did not recall having a conversation with anybody about the samples at that stage. Garda Murphy did not request the SATU report and told the Commission:

“I didn’t make any inquiries. I assumed a role in the incident of reporting guard. By assuming that role it would lead on that another member would be assigned investigating, and any such documents would be the responsibility of the investigating member.”

14.12 Sergeant Banville did not make any inquiries to follow up on the SATU report. She said that her experience was that the SATU generated a report and sent it to An Garda Síochána. She said that she never requested reports from the SATU. She expected that when it arrived in Waterford, inquiries would be made and that it would be forwarded on to the Village Garda Station, if it had not made a request in the meantime.

14.13 The Commission is satisfied on the evidence that there was no general system in place in Waterford to ensure that the SATU’s reports were received. Sergeant Banville pointed out, however, that the investigating member would

generally request such a report, if it had not been received, when gathering all the information for the file.

PETS follow up report reminders to Sergeant Epsilon

14.14 As reported above, the samples taken at the SATU examination were not moved to the PEMS store until August, 2010. As a result, the first PETS Follow Up Report Reminder in respect of the forensic samples stored in Waterford was not issued to Sergeant Epsilon until 29th September, 2010, with a second reminder issuing on 8th November, 2010, shortly before Sergeant Epsilon's retirement. Sergeant Epsilon could not recall the PETS reminders. He had been on leave from sometime in October, returning for about a week before he retired in November. No action was taken in response to these reminders. The samples were subsequently forwarded to the Forensic Science Laboratory in the course of an investigation later commenced by An Garda Síochána.

14.15 Notwithstanding the foregoing, however, when Sergeant Epsilon received the file at the end of April, 2009, he had a responsibility to inquire with Waterford Gardaí and/or the Forensic Science Laboratory to find out what the position was with the forensic samples taken from Grace at the SATU.

15. Sergeant Epsilon

15.1 In his engagements with the Commission, Sergeant Epsilon accepted responsibility for not bringing matters to the attention of his Superintendent and for not investigating. He freely admitted that, in this respect, he did not do his job, and he took full responsibility for what he did not do.

15.2 Sergeant Epsilon referred to the evidence of Superintendent Delaney and Superintendent Dolan to the Commission about what ought to have occurred had the matter been brought to the attention of either of them, rather than the reports having been forwarded to Sergeant Epsilon's Sub-District for investigation in the manner reported above. He acknowledged that he should have spoken to his Superintendent and he said that he should have brought these matters to the attention of his superiors. The manner of transfer of these matters to the Sub-District was not an issue that gave rise to concern on the part of Sergeant Epsilon at the time. The Commission is satisfied that

regardless of how matters came to him in his Sub-District, he had ample opportunity to raise these matters with his superior officers at weekly or monthly District meetings, or indeed to make a telephone call to the District Office, had he required any assistance. At the time, however, he did not consider that this was required.

- 15.3 Sergeant Epsilon did provide some important context for the Commission with respect to factors impacting his ability to perform his duties to the full over the period reported upon in this Volume. He told the Commission that, at the time, he was not in his right frame of mind and had not been for a number of years. He said that his problems were progressively getting worse and that it came to a head in 2010 when he could not go on any more. Sergeant Epsilon gave evidence that some days were just a blur to him. In 34 years of service within An Garda Síochána, he had only been on sick leave once and that was caused by influenza. He said:

“... I should have put myself sick with mental problems, stress or whatever and I didn’t and I know that my own authorities would have looked on it favourably and would have sought whatever necessary attention I needed was given to me.”

- 15.4 Sergeant Epsilon went on to explain in some detail to the Commission some experiences that had caused these significant personal problems around that time. He said that he had become very stressed and in dealing with his Garda duties *‘things were coming to a head’*. He told the Commission that he was *“not himself at the time and that some days he just could not cope”*.

- 15.5 Specifically, Sergeant Epsilon described having had to deal with a number of fatal road accidents along a particular road, and said:

“[o]n that particular road there were a lot of by-roads, turnoffs off it, it was a fine road in itself, but we had a lot of fatal accidents on it; people driving out onto the main road not seeing oncoming traffic or not able to judge the speed of oncoming traffic. The majority of the people that were killed on the road I would have known them and I would have attended at the scene, at the accident”.

- 15.6 Sergeant Epsilon described one such fatality where he had attended the scene and discovered that the victim was a close family friend. It was clear at the Commission that this was very traumatic for him.
- 15.7 Sergeant Epsilon also gave evidence as to a pattern of suicides that had taken place in the Village and adjacent to it. He described a local river that *“took a lot of people”*, saying that *“it seemed to be the way out for people down there”*. Sergeant Epsilon described to the Commission one particularly distressing incident that he had come upon which had a significant impact on him.
- 15.8 Sergeant Epsilon described his own reaction to the stress he was then experiencing in his Garda role, saying that a lot of things like this played on his mind. Looking back, he said that he should have sought professional help, but he did not do so. He told the Commission, *“I said I would overcome this, but I didn’t. It got to me and it still gets to me.”*
- 15.9 The Commission accepts Sergeant Epsilon’s evidence about the nature of these difficulties and that these were kept private by him. There was no evidence to the Commission that these issues were notified internally to An Garda Síochána at this time.
- 15.10 Sergeant Epsilon did, in time, obtain appropriate professional assistance and was concerned to complete his evidence to the Commission and to assist with the Commission’s investigation. He was forthright and helpful with the Commission in this.
- 15.11 The Commission is satisfied, based on the evidence received, that the fact that these incidents were not transferred at District Office level from Waterford to Clonmel District (as reported earlier in this Volume) was, in all likelihood, a significant contributing factor in how these incidents were dealt with in the Sub-District. At the very least, the opportunity for oversight, based on the District Office’s actual awareness of any matters it sent to the Sub-District for investigation, was absent.

16. Sergeant Epsilon retires 25th November, 2010

- 16.1 Sergeant Epsilon served for 34 years in An Garda Síochána. He was described variously by his superior officers as *“a very reliable and competent officer”*; *“very well liked by his colleagues and members of the public”*; and *“a very well turned out officer, a very professional officer.”* Inspector Bowen said that he always found him to be *“an outstanding member of the force.”*
- 16.2 Sergeant Epsilon retired on 25th November, 2010. He had not discussed either incident involving Grace with any other members of An Garda Síochána before his retirement.

17. Overview of investigation launched in January, 2011

The District Office first becomes aware of Grace’s case.

- 17.1 On 19th November, 2010, Mr. Smith wrote to Superintendent Kevin Dolan, then District Officer in Thomastown, Co. Kilkenny, following up in relation to his complaint made on 27th March, 2009. This was the first time the District Office became aware of Grace’s case.
- 17.2 In his letter, Mr. Smith informed Superintendent Dolan of the nature of Grace’s disabilities and of her living arrangements with Family X in the Village, Grace’s more recent transfer to a HSE funded placement, and of the fact that Grace had been made a ward of court.
- 17.3 Mr. Smith told Superintendent Dolan of the nature of his concerns over injuries to Grace, in the following terms:

“[i]t had been reported to me that [Grace] had presented to her day service with suspicious fingertip type bruising to her breast and upper thigh. This was the second incident of suspicious bruising reported to me in eight months, and I presented [Grace] to Waterford Regional Hospital, and made the complaint to Waterford Gardaí so that [Grace] could be seen at the Sexual Assault and Treatment Unit. [Grace] attended SATU later that day.”

17.4 Mr. Smith told Superintendent Dolan how he understood that the Garda file had been transferred within An Garda Síochána to Sergeant Epsilon in the Village Garda Station and that this station came within the administrative area of the Superintendent.

17.5 Mr. Smith explained to Superintendent Dolan how the matter was, as he saw it, *“highly complex and indeed highly controversial”*. In his letter, he elaborated on his views in the following terms:

“[Mrs. X] was a prolific foster carer who has looked after possibly more than forty intellectually disabled children in her home in [the Village] since 1980. There have been other serious complaints in this regard by parents who claimed that their children were abused by [the Xs]. This related to allegations of sexual abuse against both [Mr. and Mrs. X] and physical abuse by [Mrs. X]. I have concerns that [Grace] was also neglected and also seriously financially abused.”

17.6 He went on to say:

“[a]stonishingly, [Mrs X] is still caring for an intellectually disabled young woman under a private arrangement with her mother.”

17.7 He concluded his letter by requesting that he be informed of the status of the Garda investigation into his complaint.

Launch of Garda investigation

17.8 Arising from Mr. Smith’s letter, An Garda Síochána launched a full investigation into the two incidents that had been reported to Gardaí on 20th August, 2008 and 27th March, 2009 respectively. No prosecutions were recommended at the conclusion of that investigation.

17.9 It is of interest, for the purpose of this Volume, to note that during the course of the Garda investigation, the forensic samples were sent to the Forensic Science Laboratory for analysis. These samples comprised:

- a. Two swabs labelled “[Grace] ... *right upper chest* ...”;
- b. One swab labelled “[Grace]... *mouth*”;
- c. One swab labelled “[Grace]... *vaginal swab*”; and
- d. One swab labelled “[Grace]... *rectal swab*”.

17.10 The report prepared by the Forensic Science Laboratory, sent by it to An Garda Síochána on 12th July, 2011, stated that there was no semen present on the swabs.

18. Acknowledgement of assistance by An Garda Síochána and its liaison team

18.1 The Commission wishes to acknowledge the considerable assistance it received from An Garda Síochána in conducting its investigations. The Garda Liaison team provided a high level of service to the Commission and was always on hand to address any query the Commission had. It frequently responded with an answer on the day the query was raised and attended at the Commission offices to provide the originals of items sought. It also facilitated familiarisation for Commission personnel in various Garda systems such as PULSE and PEMS and arranged access to Waterford Garda Station to inspect their PEMS system. The Commission is most grateful for the assistance provided.

18.2 The Commission also acknowledges the assistance of An Garda Síochána in indicating to it intended changes in the role of Sergeant-in-Charge, as well as other organisational changes currently under development, to bring about improvements in its operating model. A new model of operation has been indicated to the Commission as one that will “*drive fundamental change across the organisation.*”

18.3 The Commission has been told that the Garda Operating Model Project is currently developing a Sergeant-in-Charge role profile as part of the design and implementation of its new operating model. The Commission understands the development of this role profile to be at an advanced stage. Revised and

updated organisational documentation has been indicated to the Commission to support new roles that are being introduced in the intended new Garda operating model.

APPENDIX

Sexual Assault Treatment Unit
Wingard Regional Hospital,

000000

Ref No: 09 011

S.A.T.U.

CONFIDENTIAL

Confidential Receipts

000001

Name: [REDACTED]
D.O.B: [REDACTED]

000002

Garrison House,
John's Green,
Kilkenny.

Report from;

Dr Mary J O Gorman
M.B, B.Ch, B.A.O., D.C.H., F.P.A, D.Obst., R.C.O.G., M.I.C.G.P.

Phone [REDACTED]

Email [REDACTED]

Page 1

000003

Dr Mary J.O Gorman
M.B, B.Ch, B.A.O., D.C.H., F.P.A, D.Obst., R.C.O.G., M.I.C.G.P.

Dated : 26/08/2010.
Specialist Field : Sexual Assault Unit , Waterford Regional
Hospital, Waterford
On behalf of : Gardai, Waterford.
On the instruction of :
Subject matter : Alleged sexual assault.

Your name: Dr.Mary J.O'Gorman,

Address;

Telephone Number;

Fax Number;

Email address;

Reference

000004

Name: [REDACTED]
D.O.B.: [REDACTED]

Dr Mary J O Gorman
M.B., B.Ch., B.A.O., D.C.H., F.P.A., D.Obst., R.C.O.G., M.I.C.G.P.

Report

1 INTRODUCTION

- 1.1 Name and profession Dr.Mary J.O'Gorman.
- 1.2 Dates ,location and time of examination ; 27/03/2009, at Sexual Assault Unit, Waterford Regional Hospital, Waterford.
- 1.3 Names and addresses of other medical personnel/garda present
- 1.4 Garda Mary Murphy, Badge No [REDACTED] Waterford.
- 1.5 Nurse Mary Naim.

- 1.6 Summary of case : This patient presented at A&E ,her care giver having noticed some injuries to the patient which were not there a few days earlier. A&E officer referred the patient to the Gardai who referred to the SATU.

077008

Name: [REDACTED]

D.O.B.: [REDACTED]

1.7 Summary of conclusions :

This patient had injuries to her body as per body diagram page 10 of chart. As she was suffering with a profound intellectual disability it was not possible to obtain a history of events a forensic examination and limited forensic sampling was done , for safety of patient and those present it was not possible to take some samples e.g. blood and high vaginal swabs.

[REDACTED]
[REDACTED]

[REDACTED]

000005

Name: [REDACTED]
D.O.B: [REDACTED]

Dr Mary J O Gorman
M.B., B.Ch., B.A.O., D.C.H., F.P.A., D.Obst., R.C.O.G., M.I.C.G.P.

3 Examination

Date of presentation 27/03/2009 at 21.35.

Description of alleged assault This patient was noted to have injuries by her carer while showering the patient. She had not had these injuries when previously showered by the carer a few days earlier. She was also noted to be more 'restless' recently and 'laughing' a lot that day which would be unusual behaviour for her. She was referred to A&E and thence to Waterford Gardai and SATU.

On Examination- The patient was uncooperative due to profound learning disability.

Of the head and neck: On her Left neck she has a 3 cm scratch mark (10 cm from left ear lobe).

Of the upper limbs: She had a 8cm scratch mark on her right anterior upper arm 7cm from right glenoid process (shoulder). On her lower Right forearm she had a scratch mark 5.5cm (positioned at 4 cm from right styloid process (wrist)).

Of the lower limbs: There was bruising 2.5cm x 1 cm on the Right lateral thigh positioned 11cm from iliac crest (lateral pelvic bone).

Red mottling anterior of both thighs.

Of the chest and abdomen: Left upper chest scratch mark 8cm x 8cm (positioned 16 cm from left axilla (armpit)).

000006

Name: [REDACTED]
D.O.B. [REDACTED]

Yellow bruising 1cm round left breast area, (3cm from mid line).

Of the back and buttocks: As above.

Of the genital and anal area : No perineal injuries noted. Patient resisted attempt at vaginal swabbing and sampling.

No peri anal injuries noted. Good sphincter muscle reaction.

3.2 Details of clothing given to the Gardai : None given in the Unit.

3.3 Details of samples given to the Garda.

3.3.1 One mouth swab.

3.3.2 One head hair control sample.

3.3.3 One head hair combing.

3.3.4 One right and one left nail swabs.

3.3.5 One right and one left hand nail cutting.

3.3.6 One vulval swab.

3.3.7 One Pubic hair sample.

3.3.8 One pubic hair combing.

3.3.9 One rectal swab.

No blood modules taken in interest of trauma to patient and safety.

000007

Name: [REDACTED]
D.O.B. [REDACTED]

Dr Mary J O Gorman
M.B., B.Ch., B.A.O., D.C.H., F.P.A., D.Obst., R.C.O.G., M.I.C.G.P.

- 4 **My conclusions** This patient presented to A&E Dept., Waterford Regional Hospital, with a history of body injuries noted by her carer while showering, which had not been present the previous time she had showered her. As the patient had profound intellectual disability a history could not be corroborated and due to the injuries noted the Gardai were contacted and the patient was forensic examined and limited sampling undertaken within safety and comfort limits due to the patients intellectual capacity.
- 5 Injuries were noted and recorded as per report in 3.

Dr. Mary J. O'Gorman.

Signature: M. J. O'Gorman Date: 22/08/2010

000009

Name:
D.O.B.

Dr Mary J O Gorman
M.B., B.Ch., B.A.O., D.C.H., F.P.A., D.Obst., R.C.O.G., M.I.C.G.P.

Qualifications M.B., B.Ch., B.A.O., UCD 1975 .

Diploma in Child Health UCD 1980 .

Family Planning Certificate 1979 .

**Diploma of the Royal College of Obstetricians
And Gynaecologists 1979.**

**Membership of Irish College of General
Practitioners 1985**

**Training and working with Sexual Assault and
Treatment Unit Waterford Regional Hospital since 2005**

Principal in General Practice since 1981

**Residency in Obstetrics and Gynaecology 1976-
78 at University of British Columbia**

**House Officer in Obstetrics & Gynaecology
John Radcliff Hospital Oxford 1979 -80.**

**Certificate in Sexual Assault Forensic
Examination 2009.**

FSR - Volume 5

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Volume 5

1. Scope

Term of Reference:

- 1.1 Part IV. d) "Monitoring and review of the care provided by Family X to Grace" provides:

"Establish the facts relating to:

the treatment and investigation by the SEHB, any other Health Board or the HSE of any allegations made in respect of Family X and communicated to any Health Board or the HSE by any party whatsoever, as referred to in the Devine Report."

- 1.2 The Commission's investigations under this Term of Reference focus on establishing the facts relating to the treatment and investigation by the South Eastern Health Board of allegations made in respect of Family X arising out of a private arrangement which had been made with them by one Mrs. Z to look after her daughter, Z.Z.
- 1.3 The health board's investigation was conducted in early 1993 and had its genesis in two letters written by Ms Martina Doyle in December, 1992, one to Mr. Patrick Conaty about her concern that Family X were accepting placements of children in circumstances where they had children placed with them by the health board; the other to Dr. Elizabeth Morrissey Walsh ("Dr. Walsh") about concerns that had been brought to her attention regarding Z.Z. Ms Martina Doyle was a social worker employed by the Brothers of Charity. Mr. Patrick Conaty was the Senior Social Worker in the health board Community Care Area. Dr. Walsh was Acting Senior Area Medical Officer.
- 1.4 The health board's treatment and investigation of the allegations, albeit arising out of Family X's care of Z.Z., were nonetheless of relevance to Grace, whom it had placed with Family X and who was living with Family X at the relevant time. It is pertinent to the monitoring and review of her care in the placement at

that time and to the extent to which information was shared among the various professionals and other employees of the health board with a duty to ensure her care and protection.

- 1.5 Quite apart from that, the treatment and investigation of the allegations which had been communicated to the health board were not without relevance to later developments in Grace's case. In 2008, a social worker who was new to the case prepared a report in relation to Grace and a number of other individuals who had stayed with Family X, including Z.Z. In the course of preparing that report, contact was made by that social worker with a number of individuals, including Mrs. Z. What she relayed to that social worker, what that social worker recorded in response to that, and the impact of all of this on the management of Grace's case is dealt with in Volume 1 of the Commission's Final Substantive Report.
- 1.6 Pursuant to Phase One of its investigation, the Commission is limited by its Terms of Reference to an examination only of Grace's position, with reference to Parts I to IX of those Terms. Pursuant to Part X of its Terms of Reference, the Commission is to consider the question of further investigations (if any) which may be undertaken having regard to the facts established and information in its possession.¹
- 1.7 Reference will be made throughout this Volume to the statutory providers of health service. The South Eastern Health Board will be referred to the "*the SEHB*" from time to time in this Volume. References in this Volume to "*the health board*" or to "*the board*" are also used and are intended as references to the South Eastern Health Board.

Breakdown of the Term of Reference

- 1.8 In order to establish the facts, the matters to be investigated in accordance with the above Term of Reference are broken down into the following questions:-

¹ Including the report by Conor Dignam SC in his "Review of Certain Matters Relating to a Disability Service in the South East" (29th August, 2016) and his recommendations regarding the areas to be examined, set out in chapter 4 of his report. This includes recommendations of the Dignam report concerning "Care and Decision-Making in respect of Others", "Actions of the HSE in terms of investigating/protecting others" and "Protected Disclosures" including the HSE's treatment of "whistleblowers".

- (i) were any allegations made in respect of Family X?
- (ii) if so, who made those allegations and what were the allegations?
- (iii) were the allegations communicated to any health board or the HSE?
- (iv) if so, how were they treated and investigated by the health board or the HSE?

2. Witnesses

- 2.1 The Commission heard from a number of witnesses in respect of the matters discussed in this Volume. Mr. and Mrs. Z gave evidence. Other witnesses fell into three main categories, namely: (a) health board staff during the time under consideration; (b) staff of a day unit which cared for children with special needs (referred to generally throughout as “the Waterford Day Unit” or “the Unit”), which Z.Z. attended during the time under consideration; and (c) other persons whose evidence as to facts was considered relevant by the Commission.
- 2.2 Evidence would have been taken from a number of other persons but for the fact that they were deceased by the time the Commission was established. These include Ms Kitty Greaney, who was the health board’s Children’s Officer, Mr. X, Consultant A, a paediatrician, Consultant B, a gynaecologist, and Sr. Sigma (the director of the Waterford Day Unit).
- 2.3 Mr. Conaty passed away shortly after giving evidence to the Commission. His evidence, accordingly, was heard in part. While the Commission received his evidence relating to events covered by this Volume, that evidence was incomplete in certain respects, as highlighted below.
- 2.4 In connection with this Volume, evidence was taken from Mr. Pat Conaty, Dr. Martin O’Boyle, Ms Kathleen O’Sullivan, and Dr. Elizabeth Walsh, all of whom were employees of the South Eastern Health Board during the time under investigation; from Ms Martina Doyle who, as mentioned above, was an employee of the Brothers of Charity; from a number of employees of the Waterford Day Unit, referred to as Day Unit Worker 1, Day Unit Worker 2, and Day Unit Worker 3; from Mr. and Mrs. Z; from a legal executive who was a

friend of Mr. Z's; from Mrs. T, a neighbour of Mrs. Z's; from Z.Z.'s general practitioner; and from Mrs. X.

3. Reporting relationships

Health board

3.1 The place of the key officials referred to in this Volume in the overall hierarchy of the health board organisation was as follows:-

- Dr. O'Boyle, the Acting Director of Community Care, reported to the Programme Manager (Community Care), who in turn reported to the Chief Executive Officer, the most senior official in the SEHB organisation.
- Ms O'Sullivan, the Nurse Counsellor for Parents of Children with Mental Disabilities / Advisory Nurse for the Mentally Handicapped, reported to the Senior Public Health Nurse, who in turn reported to the Superintendent Public Health Nurse, who was answerable to Dr. O'Boyle as the Acting Director of Community Care.
- Dr. Walsh, Acting Senior Area Medical Officer, reported to Dr. O'Boyle, the Acting Director of Community Care.
- Social workers reported to the Senior Social Worker, Mr. Conaty, who reported to Dr. O'Boyle as the Acting Director of Community Care.
- The Children's Officer, Ms Greaney, reported directly to Dr. O'Boyle, the Acting Director of Community Care.

Waterford Day Unit

3.2 The Waterford Day Unit was established and run by an order of nuns and was based in Waterford City. It catered for children with special needs. It received supports from consultants in Ardkeen Hospital and, occasionally, from the Brothers of Charity Services, who operated on a contractual basis with the South Eastern Health Board. The children for whom it catered had a wide range of disabilities, ranging from profound through severe to moderate to mild. Their

ages ranged, at the pre-school level, from around 18 months to two years up to around five or six years. Beyond that, ages ranged to 16 years.

- 3.3 The Unit's Director at the time under consideration in this Volume was Sr. Sigma. The Unit Supervisor, Day Unit Worker 1, was subordinate to her. Staff nurses, such as Day Unit Worker 2 and Day Unit Worker 3, were answerable in turn to Day Unit Worker 1.

Brothers of Charity

- 3.4 The Brothers of Charity provided the Diagnostic Assessment and Advisory Service which was a multi-disciplinary team composed of psychiatrists, psychologists and social workers. The service worked with children with intellectual disabilities and provided sessions to a variety of schools and services throughout the south eastern region.
- 3.5 The Brothers of Charity provided services to children with intellectual disabilities at the request of the health board on a contractual basis. The Brothers of Charity dealt with children who were referred to them, by arrangement with the health board, through schools or clinics. The Brothers of Charity did not have a general responsibility for all children with an intellectual disability in the south eastern region. The responsibility for such children remained with the health board.

4. Circumstances of Z.Z.'s placement

- 4.1 Z.Z. was born on 24th November, 1980 with intellectual and with some physical disability. She was challenging to raise and care for. Her mother was devoted to her and the Commission heard, and acknowledges, that she did an excellent job in looking after Z.Z. She obtained speech therapy and sign language tuition for Z.Z. and sought specialist advice on counteracting allergies from which she suffered. She also sought to obtain an education suitable to Z.Z.'s needs, but experienced a number of setbacks in that regard. In 1986, Z.Z. began attending the Waterford Day Unit. This was considered to be the service that best suited her needs and Mrs. Z considered it to be a wonderful place with great staff where Z.Z. was well looked after.

- 4.2 Z.Z.'s attendance at the Unit entailed a daily 100 mile round trip for her mother, who used to drive her from their home to the bus that transported her to the Unit, and pick her up there again in the evening. It was a long day. Z.Z. would have to rise shortly after six o'clock in the morning, returning home around five o'clock in the evening. Despite all this, her mother was committed to ensuring that Z.Z. successfully reached the Unit. However, the strain caused by such an arduous routine proved too much for Z.Z. and, at one point in 1988, she collapsed after returning from the Unit. Mrs. Z then asked Sr. Sigma, the Unit's director, if respite could be found for Z.Z. in Waterford for part of the week in order to reduce her travel.
- 4.3 Sr. Sigma then contacted the South Eastern Health Board and, through Ms Greaney, the board's Children's Officer, a placement was arranged for Z.Z. in Family X's house. Mrs. Z attached importance to the link with the health board as she did not have any previous knowledge of Family X. Z.Z. stayed with Family X overnight on Tuesdays and Thursdays and attended the Unit during the day. Mrs. Z paid Mrs. X directly for this service. That arrangement remained in place until the end of September or the beginning of October, 1990, when Mrs. Z was admitted to hospital for an operation.
- 4.4 While her mother recuperated, Z.Z. stayed with Family X seven nights a week. That arrangement lasted for about six weeks, after which time Z.Z. returned home at weekends. Mrs. Z used to collect her on a Friday evening and either return her to Family X on a Sunday night or drive her directly to the Unit on a Monday morning, an arrangement which continued until around December, 1992. During her stay with Family X, an ambulance or bus took Z.Z. to and from the Unit. It appears to the Commission, from the evidence, that Z.Z., in reality, would not have been able to continue attending the Unit if the arrangement with Family X had not been in place.
- 4.5 A "Form of Contract for Child Boarded-Out" was signed in respect of Z.Z. on 26th September, 1990 by Mrs. X as "*foster parent*", Ms Greaney, and a health board official. The purpose of this document was not clear, given that the arrangement, albeit one arranged with the help of the health board, was essentially a private one as between Mrs. Z and Mrs. X. There was, indeed, no foster care arrangement in place under the Boarding Out of Children

Regulations, 1983 (“the Regulations of 1983”) and these regulations had no applicability to the situation.

- 4.6 The essential narrative which follows in this Volume deals with concerns communicated to the health board by Ms Doyle and the Waterford Day Unit arising from Z.Z’s stay with Family X and the health board’s subsequent treatment and investigation of those concerns. These concerns centred on Z.Z’s general welfare and on the development of what was recorded at the time as “*sexualised behaviour*” on her part.
- 4.7 Z.Z was, like Grace, a vulnerable child. The existence or absence of knowledge on the part of the health board of issues of concern for another vulnerable child in the care of Family X is important in examining the board’s performance in dealing with the issues arising for the management and care of Grace.

5. Applicable guidelines

- 5.1 In the course of this Volume, reference will be made to certain documents referred to in the First Substantive Interim Report, including the Department of Health’s Guidelines on Procedures for the Identification, Investigation and Management of Child Abuse, revised edition, July, 1987 (“the Guidelines”) and the Regulations of 1983.
- 5.2 In 1975, the Department of Health set up a committee to discuss the issue of non-accidental injury to children. This committee found that there was a problem in Ireland with regard to such injuries and it recommended that the issue be examined in detail. It suggested procedures to deal with cases of non-accidental injury to children and to ensure the coordination of persons and bodies having a responsibility in the area. The first report of the Committee on Non-Accidental Injury was published in 1976 and formed the basis for all subsequent guidelines issued by the Department of Health. The first edition of National Child Abuse Guidelines, (the “*Memorandum on Non-Accidental Injury to Children*”) was published in 1977. A later edition was published in 1980, followed by another revised version in 1983.
- 5.3 In 1987, the Department of Health published the set of Guidelines that were applicable over the time under review in this Volume. These provided a clear

definition of “*abuse*” as comprising “*physical injuries, severe neglect and sexual or emotional abuse*”. The Guidelines stressed the importance of inter-agency and inter-professional work and established the roles and responsibilities of organisations and professionals with child care functions. They emphasised the methodology of the case conferences in the process of management of cases of suspected abuse.²

- 5.4 Given their applicability during the timeframe under consideration pursuant to this Term of Reference, relevant parts of the Guidelines are discussed below

The Guidelines of 1987

Purpose of the Guidelines

- 5.5 The purpose of the Guidelines was to provide guidance generally for personnel working with children, particularly for health and social service agencies, on the identification, investigation, and management of child abuse. “*Child abuse*” was said to be harm resulting from “*direct acts, or by failure to provide proper care, or both. Such acts include physical injuries, severe neglect and sexual or emotional abuse*”.

Responsibility for monitoring, coordinating, and managing child abuse allegations

- 5.6 Under the Guidelines, responsibility for monitoring and coordinating the management of such cases rested with the health boards. Within the health board, the Director of Community Care / Medical Officer of Health (“the Director”) had overall responsibility for the monitoring and coordination of cases of child abuse occurring in his area.
- 5.7 Under Part 2.1 of the Guidelines, the Director was the person to whom all cases were notified, and whose responsibility it was to ensure that arrangements were made to gather all necessary information in each case, to consult with appropriate personnel, and determine with them the need for a case conference. Part 2.1 also provided that he was to arrange for case conferences

² See also, ‘Child Protection Practices in Ireland’ Buckley et al. Oak Tree Press (Dublin) 1997.

in consultation with appropriate personnel and record any decision not to hold one, oversee the general management and coordination of cases, ensure that actions decided upon were carried out, and maintain lists of confirmed and suspected child abuse cases in his area. The Guidelines emphasised the need for cooperation internally within the health board and with external agencies like An Garda Síochána. It was acknowledged in the Guidelines that, in carrying out these functions, the Director was “*heavily dependent*” on the senior members of his team, particularly the Senior Social Worker, the Superintendent Public Health Nurse and the Senior Area Medical Officer. The Guidelines referred to the Director having a “*coordinating role*”.

Identification and investigation of child abuse

- 5.8 With regard to the identification and investigation of child abuse, the Guidelines provided that the initial steps were to establish the relevant factual circumstances of the child and the possible sources of harm or danger. Close cooperation between child care and law enforcement agencies was said to be “*essential*”, and they advised that local arrangements be agreed between health boards and the Gardaí on the investigation of cases. They provided that the health board needed to pursue all cases, with involvement of the Gardaí depending on whether it appeared that an offence had been committed.

Action to be taken where child abuse suspected

- 5.9 The Guidelines set out actions to be taken by health board personnel who suspected that a child had been abused. The matter was to be discussed with a senior colleague whose responsibility was then to report the matter to the Director or his deputy, giving details of his concern and other relevant information. Arrangements were then to be made to follow up the case along the lines set out later in the Guidelines. Guidance on what to do was also set out in respect of other persons, such as general practitioners.

Role of the social worker

- 5.10 The Guidelines set out the steps which were normally to be taken by what they described as the health board’s Community Care Social Worker. These included speaking to the person making the complaint and checking his

knowledge of the child and the child's family and possible risks to other children. The Director was also to be informed. The situation was to be discussed with the parents/guardians and the circumstances assessed. An explanation of the incident or injury was to be sought from the parents/guardians. Checks were to be made with other community care personnel and other agencies who might know the family. The child was to be seen and its appearance and behaviour and its relationship with its parents or guardians noted and assessed. Observations, assessment, and explanation of any incident or injury were to be recorded. The Senior Social Worker was to be consulted and the next action decided on. The Senior Social Worker was responsible for making arrangements with the Director or his deputy for a case conference where that was considered necessary. Where the report or allegations proved unfounded, the matter was to be recorded on file and the Senior Social Worker and Director notified. The referring agent and all involved personnel were to be notified.

Case conferences

- 5.11 The Guidelines also accorded a central position to case conferences. These provided a forum for the exchange of information between different professionals involved with the child and family, leading to recommendations to individual agencies for action.
- 5.12 Requests for the holding of case conferences on child abuse cases were to be made to the Director.³ If he agreed to hold one, he was to set the date for the conference and have arrangements made for relevant persons to attend. In non-urgent cases, a case conference was to be held as soon as possible, so that it could contribute to establishing whether there was child abuse and recommend initial action. In urgent cases, it was envisaged that a case conference would probably take place after initial action had been taken by investigating agencies. The Guidelines also recommended standardisation of case conference procedures in a number of ways.

³ The Guidelines did not specifically set out a list of persons who might request the Director to convene a case conference. Where requests emanated from the Social Work Department, the Senior Social Worker was to make arrangements with the Director where that was considered necessary.

- 5.13 The Guidelines provided that the Gardaí, if not already involved, had to be notified as quickly as possible where a breach of the law was indicated.
- 5.14 The Guidelines also provided for the collection of information on child abuse cases, whether suspected or confirmed. This was the responsibility of the Director, who was to review the list of such cases at least annually. Information was disclosable at his discretion.

Sexual abuse

- 5.15 The Guidelines stated that any complaint of sexual abuse made by a child was to be taken seriously and should prompt the necessary investigative and validation process. Where there were reasonable grounds for suspecting child sexual abuse, the Director was to report the matter to the Gardaí. Persons to whom suspected offences came to light were to contact the Director who was then to arrange for further investigation. Multi-disciplinary teams were to be designated for the examination of children and the validation of alleged child sexual abuse.
- 5.16 The Guidelines themselves provided that health boards and hospitals were to bring the Guidelines to the attention of all staff likely to come in contact with cases of child abuse. The Director was to arrange periodic meetings of key staff involved in managing such cases to exchange views and ensure those newly involved were aware of the support available to them.

6. Knowledge of health board staff in child protection-related matters

- 6.1 Evidence was given by a number of health board personnel about their knowledge of such matters as the Child Abuse Guidelines and other relevant matters pertaining to the health board's interactions with children.

Dr. Martin O'Boyle

- 6.2 As set out in Chapter 4 of the First Substantive Interim Report, Dr. O'Boyle took up the role of Acting Director of Community Care in 1987. The Commission has reported upon his role and responsibilities in the context of that chapter. He was responsible for a number of disciplines, learning as he went along, in that

he “*got an impression of what they were doing and what were the areas of difficulty they were having by having to meet with them quite frequently.*”

- 6.3 Dr. O’Boyle was unfamiliar with the daily work of the Social Work Department before he took up his post. After he was appointed, however, Mr. Conaty, the Senior Social Worker, used to come and see him early in the morning about twice a week. They used to discuss issues arising and Mr. Conaty would seek approval for proposed courses of action. They also met at the monthly meetings of heads of department. In these ways, Dr. O’Boyle became acquainted with the activities of the Social Work Department.
- 6.4 Dr. O’Boyle’s knowledge of the regulatory framework pertaining to social work decisions was, however, by his own admission, “*extremely limited*”. He was guided by Mr. Conaty with regard to the regulations being used and relied on Mr. Conaty’s expertise. He did not recall being sent on any training courses or that any steps were taken to familiarise him with regulations governing social work matters after he took up his post.
- 6.5 Dr. O’Boyle was not familiar with the content and detail of the Guidelines and did not really know if he was aware of his responsibilities under Part 2.1 of the Guidelines, though he indicated that he was aware of them as a matter of practicality.
- 6.6 Dr. O’Boyle did not think that he was aware of the need for the health board to agree arrangements with local Gardaí under the Guidelines. He could not recall his procedure for notifying them, or whether there were notification protocols in place during his time as Acting Director. He said that he was “*probably not*” aware of the obligation in the Guidelines to notify Gardaí as quickly as possible where a breach of the law was indicated.
- 6.7 Dr. O’Boyle was not involved at any stage during his tenure as Acting Director in undertaking any training courses concerning child abuse allegations or in providing any training to the staff subordinate to him. Nor was he aware if training in relation to such matters had been given to such staff during his tenure.

- 6.8 With regard to case conferences, Dr. O'Boyle was unaware that the Guidelines provided that decisions on holding them were to be made by the Director of Community Care. He said that *"most commonly"* they were convened by a social worker or doctor, who might inform him of this. He acknowledged that case conferences might occasionally be arranged without his formal approval, in that other agencies could arrange them and that he would get a letter in that regard, saying *"I suppose in a sense they got approval from me"*.
- 6.9 Dr. O'Boyle said that around a quarter to a third of his time as Acting Director was taken up with child care, fostering and disability services.

Dr. Elizabeth Walsh

- 6.10 Dr. Walsh did not recall being provided with any specific training when she returned from her leave of absence in the 1980s on matters concerning her areas of responsibility. However, the health board facilitated her in training and *"upskilling"* in the context of medical evaluation of child sexual abuse. In the early 1990s, she attended practical training sessions in child sexual abuse in Temple Street Children's Hospital in Dublin and in the mid-1990s she took part in a residential course over a number of days in Leeds. On an almost annual basis from 1996 she attended sessions on medical evaluation of child sexual abuse in San Diego in the United States.
- 6.11 Dr. Walsh could not specifically recall the Guidelines, saying, *"If you ask was I aware of their existence I don't know, probably yes."* She recalled that the Director of Community Care / Medical Officer of Health had *"overall responsibility for the management and that...the initial assessments or investigations were carried out by the Social Work Department under the auspices of the Senior Social Worker"*.
- 6.12 She said that she had *"very little"* familiarity with the Regulations of 1983, explaining *"I saw it as the remit of the Social Work Department and I know at that time it was delegated, we'll say, to Kitty Greaney, the Children's Placement Officer"*.

Ms Kathleen O'Sullivan

- 6.13 Ms O'Sullivan was familiar with the Guidelines and of the obligations they imposed on the Director as to how to manage reports of child abuse and call case conferences and matters of that nature. The Social Work Department used to contact her in the event of a case conference being convened and she had been at many such conferences.

Mr. Pat Conaty

- 6.14 Mr. Conaty was familiar with the Guidelines at the time of the events discussed in this Volume and said that they would be consulted after a referral was made. He described the Guidelines as *"the modern Bible"*, saying *"all you could do was work to the best of your ability within those Guidelines"*.
- 6.15 Regarding the convening of a case conference, if Mr. Conaty recommended it, he said that he would contact the Director to fix a date. Speaking of his involvement in referrals, he said that having had a child medically examined to diagnose the cause of injuries (where relevant) he would carry out an investigation and make a recommendation to the Director. Mr. Conaty's evidence was that a case conference would probably be called at that point.
- 6.16 Mr. Conaty said that he was notified of changes in legislation and that, with regard to being updated on new developments in matters like statutory developments and social work, there used to be meetings with an official from the Department of Health which he was expected to attend.

7. Narrative of events

Examination of concerns conveyed to health board

- 7.1 It must now be established precisely what allegations were made in respect of Family X, communicated to the health board, and later investigated by it. The basis of the concerns which triggered the health board investigation was contained in two letters written by Ms Doyle on 2nd and 22nd December, 1992 to Mr. Conaty and Dr. Walsh respectively. The first letter expressed concern about Family X taking care of too many children. The second referred to

concern expressed by staff in the Waterford Day Unit about Z.Z. These concerns were subsequently discussed at a meeting between Ms Doyle and various officials of the health board in mid-January, 1993. That meeting also had available to it a report prepared by the Waterford Day Unit outlining its concerns about Z.Z. The outcome of the meeting was that Mr. Conaty was tasked with conducting an investigation, which culminated in his preparation of a report for the attention of Dr. O'Boyle.

- 7.2 The report of Mr. Conaty, submitted to Dr. O'Boyle, was undated but attached to a covering letter of 23rd February, 1993. A copy of the report and the covering letter are contained in the Appendix to this Volume.

Ms Doyle's concerns about Family X taking care of too many children

- 7.3 In the early 1990s, the Brothers of Charity became concerned about Mr. and Mrs. X taking on too many child-minding commitments. As discussed in Chapter 4 of the First Substantive Interim Report, an annual meeting took place with Mr. and Mrs. X to see if they were available to participate in the Holiday Placement Scheme. In May, 1991, a social worker in the Brothers of Charity paid them a home visit and recorded that they were "*very keen*" for the scheme to be scheduled for July and August of that year. It was stressed during that meeting that they should not have other children / adults staying while children / teenagers in the scheme were placed with them. They indicated that they had "*no other private arrangements*" made regarding children / teenagers coming to stay with them but that, if they had, they would inform the Brothers of Charity. Subsequently, however, the Brothers of Charity learnt that Mr. and Mrs. X were also taking care of a woman with disabilities every second weekend. They brought this to the attention of the health board, suggesting that it might wish to consider Family X's ability to cope with the number of children who would be placed with them on the scheme that summer. Although the health board was satisfied that the scheme should continue, it came to an end when Family X, which was the sole host family, declined to participate in it in 1991.
- 7.4 Ms Doyle was on maternity leave when the scheme came to an end but she formed her own independent concerns about continued placements with Mr. and Mrs. X. This prompted her to write to Mr. Conaty on 2nd December, 1992, saying:-

"I write to you about Mr. and Mrs. [X], [address given] whom you know have children with mental handicap placed with them by the Health Board. As you are aware, I have not placed children with them, on the holiday placement scheme, for some time now and therefore have not had recent contact with them. However, I have heard that children continue to be placed with them through Health Board channels and also by private arrangement.

I am very concerned about this and would welcome discussion on the matter at your earliest convenience".

- 7.5 This letter was copied to Dr. Walsh (who had taken up a half post in disability services in Waterford Community Care in 1992, after the Scheme had ended), Ms O'Sullivan, Ms Greaney, and a social worker in St. Patrick's, Kells Road, Kilkenny.
- 7.6 Ms Doyle indicated during her evidence that the background to her statement that she had not placed any children with Family X on the Holiday Placement Scheme for some time was the discovery by the Brothers of Charity that they had been hosting another person (*i.e.* other than Grace) with special needs. She explained that, in the months before she wrote that letter, she had heard that families were making arrangements with Family X for their children to be placed with them on a short-term basis. She said that she wanted people who might be involved in any way with Family X to be aware of that fact and, in addition, that there was also someone else (Grace), who had been placed there by the health board. Her concern was that they should know about the number of children that were in the house and whether that was over-burdening the household. The people she circulated her letter to were, she said, *"people who may become aware or be linked with families"* who were making such arrangements with Family X. She explained that *"it was really just a matter of information so that people would be aware of it."* She said that she did not believe that she had spoken to the staff at the Waterford Day Unit or with Mrs. Z by the time she sent the letter in 1992.
- 7.7 Ms Doyle's working relationship in an *"everyday way"* was with Dr. Walsh and Ms O'Sullivan in terms of children with disabilities. Nonetheless, Ms Doyle and

Mr. Conaty knew each other in their roles as social workers and would have occasional contact in that regard.

7.8 Mr. Conaty was also aware of Family X as foster parents in the South East, though he could not recall if he knew whether they had any foster care children placed with them under the auspices of the health board. He said that he knew that they had children in what he termed “*foster care*” from the Brothers of Charity and had gleaned information about the Holiday Placement Scheme at meetings. He said that he did not know, contrary to what Ms Doyle’s letter suggested, that the health board had placed children with mental handicap with them. Nor did he know at that time that she had not been placing children with them, or of the “*private arrangement*” referred to in her letter, until he met Family Z, which will be discussed in greater detail below. Notwithstanding Mr. Conaty’s evidence, it is clear from his participation in the case conference in October, 1989 that he knew that Grace had been placed with Family X.

7.9 Dr. O’Boyle said that he was “*certainly made aware*” of Ms Doyle’s letter and thought that that was when Ms Doyle wrote to him “*effectively stating that there was a need for a case conference with regard to [Family X]*”.⁴ Ms Doyle did not, it appears, receive any response from him. Neither Dr. Walsh nor Ms O’Sullivan remembered receiving Ms Doyle’s letter.

File minute of 4th December, 1992

7.10 Ms Helen O’Brien, a health board social worker, made a handwritten note on 4th December, 1992 which recorded Ms Doyle as being concerned about using Family X, “*based on factual reports and on ‘grapevine’ information*”. The note read:

“? level of care / space

? lack of info re other placements.

⁴ This would appear to be a reference to a subsequent letter she wrote to Dr. O’Boyle of 14th January, 1993 (discussed below), where she referred to a forthcoming meeting with health board personnel, which Dr. O’Boyle seems to have taken as a reference to a case conference.

? failure to notify each worker involved.

? lucrative business.”

- 7.11 It then referred to three individuals, including Grace, and brief details of the apparent arrangements with Family X regarding their stays there.
- 7.12 Ms O'Brien indicated that her note was a record of a telephone message from Ms Doyle, with whom she had been connected by the health board's switchboard. Ms O'Brien explained that it was not unusual at that time for the switchboard operator to connect a caller with someone from the Social Work Department who could take a message on behalf of the person with whom the caller wished to speak. Ms O'Brien, who joined the health board in 1980, indicated that she acted as a *“generic social worker”* up to the time of the enactment of the Child Care Act 1991, after which she became more focused on child protection. She indicated that she had no knowledge of any of the people referred to in the written message at that time and had no recollection of taking the telephone message. She did not begin working in the area of intellectual disability until 1995.
- 7.13 Ms Doyle said that the content of Ms O'Brien's note was in line with her letter to Mr. Conaty, though she queried aspects of it, saying *“I wouldn't have had a query about level of care”*. Ms Doyle told the Commission that the reference to *“lucrative business”* was not, she felt, something she had on her mind. The concern expressed by her to Mr. Conaty was not based on her having personally seen any of the persons staying with Family X at that point.

Z.Z.'s presentation at Waterford Day Unit

- 7.14 When Z.Z. began attending the Waterford Day Unit, she presented as a much loved and very well cared for young child. The Unit Supervisor, Day Unit Worker 1, recalled her being *“immaculately turned out”* and *“shining”* when she arrived. She described Mrs. Z as *“a brilliant mother”*. Day Unit Worker 2 echoed this, saying that she was *“always dressed, really beautifully”* and was *“a really well looked after young child”* whose hair and clothes were *“excellent”*.

- 7.15 Z.Z.'s initial attendance coincided with her being placed on a special diet designed to counteract certain food allergies, which had a calming effect on her. Her mother used to give her the foods required by the diet when she was attending the Unit and later, when she began staying with Family X. She told the Commission that when Z.Z. began staying with Family X, she supplied Family X with goats' milk, meat and potatoes in adherence to Z.Z.'s diet. Mrs. Z explained in evidence that Z.Z.'s behaviour improved significantly when she adhered to her tailored diet.
- 7.16 After Z.Z. began staying with Family X, the staff of the Unit told the Commission that they noticed a deterioration in her presentation. They referred to her "*unkempt appearance*" and to the deterioration in the condition of her hair which, having been initially clean and shiny, became greasy and looked like it had not been brushed or combed. They said that Z.Z. was wearing clothes that did not appear to be hers. She did not seem to have with her the special food which her mother normally provided. She became more hyperactive and agitated. Such of these observations, given in evidence to the Commission, were communicated to the health board in the course of its investigation, are set out below.
- 7.17 Z.Z. also presented with injuries that were unaccounted for, which are dealt with below.

Communication of concerns by Unit

Mrs. Z

- 7.18 Mrs. Z recalled being told by Day Unit Worker 2 about these developments in the months leading up to December, 1992. She had also read them in a notebook prepared by the Unit regarding Z.Z. and which accompanied her back to Family X each day, with Mrs. Z having it at weekends.⁵

Ms Doyle

⁵ While Mrs. X denied ever having such a book for Z.Z., she was clearly mistaken in that regard because the Commission obtained a notebook for Z.Z. for the year 1990 and the existence of such notebooks was also supported by the evidence of the Unit Supervisor, Day Unit Worker 1, and various references to them in the Unit's report about Z.Z. which it prepared in January, 1993, considered below.

7.19 The Unit also told Ms Doyle of its concerns about Z.Z. Ms Doyle had no previous dealings with Z.Z. As part of her role as a social worker with the Brothers of Charity, she attended the Unit on a monthly basis to conduct sessions with the children there. If the staff had concerns about an injury to a child, they used to raise them with her and she would then bring them to the health board's attention. At no time, however, did Ms Doyle have a formal role as a liaison between the Waterford Day Unit and the health board or any responsibility to act as such. Ms Doyle indicated that the concerns would have been conveyed to her some time in December, 1992, after she had written to Mr. Conaty. She was in the Unit on 1st December and 18th December, 1992. Given she wrote to Mr. Conaty on 2nd December, 1992 (when she raised concern about Family X's taking care of too many children), it appears likely to the Commission that she was apprised of these concerns on 18th December. This accorded with Day Unit Worker 2's evidence, which was that she thought that the concerns were raised with Ms Doyle around the end of 1992.

7.20 Ms Doyle asked the Unit to prepare a report and forward it to Dr. Walsh in the health board.

The Waterford Day Unit's report

7.21 On foot of Ms Doyle's request, Sr. Sigma and Day Unit Worker 2 prepared a report on Z.Z. on 12th January, 1993, drawn from the Unit's files, which was sent to Dr. Walsh. Mrs. Z was not sent a copy of the report. The report recorded as follows:-

"[Z.Z.] has attended this unit since 30/6/86. In October 1990, to relieve family pressures, already present but exacerbated by Mrs. [Z's] hospitalisation, respite care with Mr. and Mrs. [X] was arranged. It was a private arrangement between [Family Z] and [Family X].

[Z.Z.] has tested positively to various food allergies and is on a special diet to counteract side-effects, which constitute vomiting, retching, fluctuations in mood, behaviour, motor ability and cognitive functioning. By February 1991, there were strong indications that this diet was not being adhered to. Mrs. [Z] was

informed by the Unit and discussed same with [Family X]. There was some improvement for approx. ten days, after which [Z.Z.] again lapsed into hyperactivity, poor gait and temper tantrums. This was a pattern that was to continue for the duration of respite care. In time, the issue of diet became just one area of concern. The following are details of observations that also gave rise to concern for [Z.Z.'s] welfare. All events and concerns were discussed with Mrs. [Z] as they occurred.

April 1991: Over a period of weeks, [Z.Z.] was observed to be again, exhibiting symptoms of food allergies and also some new behaviours ie; pulling up and down panties and exploring her genital area. No discharge or other signs of infection were noted. Situation closely monitored from this time.

12/7/91; On arrival from [Family X], bruising noted to r. shoulder, arm, lumbar region and rib cage. Same queried but no explanation was offered. New behaviours again observed, which were to continue. These were, unprompted alternating periods of tears and laughter, fright at sudden movements and withdrawal from people.

September 1991; Following week-ends at home, [Z.Z.] became reluctant to leave. She resisted getting up and dressed and would be tearful on arrival at the unit.

28/11/91; On arrival from [Family X], bruising to r. cheek and l. jaw noted. Same query with no response.

10/1/92; Scabbed area to crown noted on arrival from [Family X]. No explanation offered.

24/02/92; On arrival from [Family X], bruising to underside of l. arm and l. hip noted. No explanation.

31/3/92; On arrival from [Family X], bruising under l. eye noted. No explanation.

22/7/92; Scratches to l. side of the neck noted. No explanation from [Family X].

7/9/92; Mark resembling bite and also bruising to l. shoulder noted on arrival from [Family X]. No explanation.

21/9/92; Having been approached by the unit, due to increased concern for [Z.Z.'s] welfare, Mrs. [Z] agreed to keep [Z.Z.] at home for a two week observation period, to compare behavioural trends. During this period, all adverse behaviour abated but re-emerged within two days of returning to respite care.

22/10/92; Finger mark pattern of bruising to r. cheek noted on arrival from [Family X]. No explanation.

3/12/92; 1½ inch scratch to l. hand noted. Appetite very poor over the following week, culminating in refusal of all food and drink in the unit. [Family X] report that there are no changes in appetite when [Z.Z.] is with them. Mrs. [Z] was asked to take [Z.Z.] to her G.P. which she did and a urinary tract infection was diagnosed.

Other areas of care were also considered to be unsatisfactory. Despite adequate provision of clothing by Mrs. [Z], [Z.Z.] was poorly dressed and her appearance became generally unkempt. Personal hygiene was particularly poor and her hair was usually matted and unwashed.

21/12/92; Respite care terminated.

January 1993; To date no further incidents. Behaviour satisfactory."

New behaviours

- 7.22 With regard to the “*new behaviours*” referred to in the report, Day Unit Worker 2 told the Commission that around April, 1991, Z.Z. began doing things she had not seen before, namely pulling her pants and panties up and down and smacking herself on the bottom, “*laughing hysterically*”. Sometimes, if she had an object in her hand, she might put it between her legs and thighs. There was no pattern to this behaviour, other than that she observed it on a weekly basis between April, 1991 and December, 1992. She showed it to Day Unit Worker 3 who was “*alarmed*” and told her that she had never seen Z.Z. exhibit this behaviour before. Day Unit Worker 3 described it to the Commission as “*something quite unusual*” and untypical of Z.Z. Day Unit Worker 2 said that the behaviour made her wonder, having had a concern that Z.Z.’s behaviour was of a sexual nature, that it might be that she was being abused. Insofar as the report for the health board was concerned, however, no reference to potential sexual abuse was made and Day Unit Worker 2 told the Commission that that was because it could not be proved. She said:

“I imagine because I was putting that interpretation on the behaviour but maybe not everybody was putting the same interpretation on it. I suppose if I was completing a report I could only comment on what I could really stand over and say this is factual. The sexual abuse couldn't be proved, you know, that is why it wasn't put in there”.

- 7.23 While Day Unit Worker 2 thought that she had mentioned the “*new behaviours*” to Mrs. Z, she did not mention them in the context of any sexual connotation. Mrs. Z could not recall being told of Z.Z.’s pulling her pants up and down.
- 7.24 As regards the rest of the report, Mrs. Z did not have a specific recollection of the individual dates and incidents mentioned in the Unit’s report, but she generally remembered being told by Unit staff, particularly Day Unit Worker 2, about bruising to Z.Z. at different times. Mrs. Z said that the issues concerning Z.Z. outlined in the second paragraph of the report relating to her diet had been discussed with her.
- 7.25 Day Unit Worker 2 said that she discussed the “*new behaviours*” with Ms Doyle on one occasion and thought she mentioned to Ms Doyle that “*there might be sexual abuse*”. Ms Doyle did not have a precise recollection of their discussions

and could not recall from memory if Day Unit Worker 2 had mentioned any concerns to her of a sexual nature, suggesting at one point that the primary thrust of her complaints concerned such matters as unkempt presentation. However, Ms Doyle recalled being told by the Unit in December, 1992 that Z.Z. had vaginal discharge for a period of time in 1991. Day Unit Worker 2, however, did not recall mentioning that.⁶ Ms Doyle also recalled that there had been some mention in her discussion with the Unit staff of sexualised behaviour of a more general nature and said that a reference in the Unit's report to Z.Z.'s pulling up and down her pants, was in her mind before she saw that report.

- 7.26 The Commission is satisfied from her evidence that Ms Doyle was told by the Unit in late December, 1992 of concerns about Z.Z.'s presentation, her pulling up and down of her pants, and her having vaginal discharge. As will be seen, this raised a concern in Ms Doyle's mind about potential sexual abuse.

Behaviour witnessed by Mrs. Z and Mrs. T

- 7.27 During her evidence, Mrs. Z gave an account of what she considered sexualised behaviour exhibited by Z.Z. when she was playing with her one day in their sitting room at home in December, 1992. She told the Commission that this behaviour was repeated shortly afterwards for her neighbour Mrs. T, and on a subsequent occasion at the Waterford Day Unit.

- 7.28 The evidence before the Commission in this regard gave rise to a question as to whether Mrs. Z was mistaken as to the date of this incident and what she said flowed from it at that time. Establishing whether her recollection of all this is correct is important in understanding precisely what allegations were being investigated by the health board in early 1993, particularly because other concerns were communicated by Ms Doyle to the health board at that time about Family X and about concerns that the Waterford Day Unit had for Z.Z., who was being cared for by them.

- 7.29 Mrs. Z described how, one Sunday afternoon, her husband and her other children went for a drive. She stayed at home with Z.Z. and was playing hide

⁶ As will be seen below, when Ms Doyle came to write to Dr. O'Boyle on 14th January, 1993 about Z.Z., she outlined four main concerns, which she emphasised in evidence were allegations, one of which was sexual abuse arising out of vaginal discharge in May, 1991. The others were decrease in physical care and hygiene, non-adherence to diet, resulting in behavioural management problems, and the observance of physical marks.

and seek with her in the sitting room. While they were playing, Mrs. Z said *"I will catch you by the bum" or "I will catch you by the ass"*, whereupon Z.Z. stood up and became very serious. She walked from behind the couch to the front of the fireplace and then pulled down her pants, lay down on the ground and raised her two legs into what Mrs. Z described as a *"sexual position"*. Mrs. Z told her not to do that and to pull up her pants, which she did. Mrs. Z said that a friend of hers, Mrs. T, called by. Mrs. Z told her what had happened and asked her if she would go into the room with Z.Z. and repeat the words she had used. Mrs. T did so and this prompted the same reaction from Z.Z. Mrs. Z and Mrs. T discussed what had happened and decided that the next morning, Mrs. Z would go to see Z.Z.'s general practitioner.

7.30 Mrs. Z believed that this happened in early December, 1992, after she had consulted Z.Z.'s general practitioner about a urinary tract infection that Z.Z. was suffering from on 3rd December, 1992. It may be noted that the Waterford Day Unit's report (set out above) contained an entry of 3rd December, 1992 which recorded that *"Mrs. [Z] was asked to take [Z.Z.] to her G.P. which she did and a urinary tract infection was diagnosed"*.

7.31 Mrs. T, during her evidence on this matter, recalled paying Mrs. Z a visit and being asked by her to go into the sitting room and say something to Z.Z. She could not recall the words she was asked to use, but she said that when she uttered them, Z.Z. looked at her and reclined on the ground, spread her legs and stared at her. She told the Commission that she thought that the incident took place around the end of November or December, 1992. She thought that it correlated with her and her husband's return from England, where they had gone in 1991. However, her evidence as to when they left for England that year and how long they spent there was quite confused and varied. One calculation would have seen them returning to Ireland in February, 1993. Mrs. T was unable to say which timeline could be relied upon. Asked why she thought it happened in 1992, she said:

"...I don't know. I just think it did. If somebody told me different -- I just know it happened, I can't tell you the date or the time to be quite honest with you, but I just reckon it was around that time because it kind of fitted in with my timeline, that's it...I

wouldn't be 100 per cent sure of the time. I am just sure of the incident, that's all".

7.32 When asked if the incident could have happened before she went to England in October, 1991, Mrs. T said that *"I honestly can't say yes or no...I am just assuming it was around that time [i.e. towards the end of 1992]"*. She said that she could *"visualise the incident, but I really can't say the time...I wouldn't be able to give you a date"*, saying that she was *"terrible with dates"* and could not really remember days or time.

7.33 Mrs. T simply could not recall when this incident occurred.

Appointment with Z.Z.'s general practitioner

7.34 Mrs. Z said that she went to see Z.Z.'s general practitioner the Monday morning immediately following the incident. She said in her evidence that Z.Z.'s general practitioner examined Z.Z. and told her that Z.Z. had been *"breached"*. Mrs. Z said that Z.Z.'s general practitioner recommended her to have Z.Z. examined by Consultant A, who was a paediatrician and a cousin of Mrs. Z's, telling her that it was *"very, very serious"*. Mrs. Z said that she rang Consultant A subsequently, telling the Commission that she did not need to make an appointment as he was her cousin.

7.35 In her evidence, Z.Z.'s general practitioner said that she was not told by Mrs. Z about an incident with Z.Z. in December, 1992 or, indeed, at any time in 1991, 1992 or 1993. She said that she would not do a gynaecological examination on a minor and that she would refer them to the Sexual Assault Unit in Cork (then in the South Infirmary) if a patient presented in these circumstances. As regards her alleged use of the word *"breached"*, she said *"The word 'breached' is not part of my medical dictionary... The only time I would use breach is for a breech delivery for a baby or a breach of confidentiality. It is not a medical term I would use...It is just not part of my vocabulary"*. She said that she never said anything of that sort to Mrs. Z at any stage.

7.36 The record of 3rd December, 1992 in the Waterford Day Unit's report, referred to above, indicates that Z.Z. attended her general practitioner on that date and that a urinary tract infection was diagnosed.

- 7.37 However, Z.Z.'s general practitioner's records did not contain any note of an examination of Z.Z. at that time. It does not necessarily follow from this that no examination took place, because her records regarding Z.Z. were incomplete, something which she acknowledged in evidence, saying *"my record keeping could have been better back then"*.
- 7.38 In that regard, her records in respect of Z.Z. did not contain any entries from March, 1990 to September, 1994, when there was an entry, and thereafter from that point until June, 1997, when there was another entry, and thereafter until a date in 2004. However, the incomplete nature of her notes was illustrated by the following two instances:
- (a) on 12th January, 1997, Z.Z.'s general practitioner wrote to an unnamed doctor thanking him for seeing Z.Z. at a time when, her letter recorded, Z.Z. was vomiting and complaining of abdominal pain, (subsequently diagnosed with appendicitis). This was not in her records. Z.Z.'s general practitioner told the Commission that she was surprised by this omission;
 - (b) on 13th August, 2001, Z.Z.'s general practitioner also wrote a letter of referral to a medical consultant. She told the Commission that she had no records in her notes in relation to the matters raised in the referral letter. Z.Z.'s general practitioner agreed that significant issues suffered by a patient leading to a referral would be something she would record in her notes, saying, *"[i]t would be my practice to record them in my notes, but it is not recorded in my notes"*.
- 7.39 The only entry in Z.Z.'s general practitioner's notes bearing any resemblance to Z.Z.'s behaviour as alleged to have occurred in her home in December, 1992 was dated 22nd February, 2012, which stated *"Still constipated aggressive +. Bold episode, → lay on floor + removed jeans. [Mrs. Z] shocked. Will consider action"*. During her evidence, Z.Z.'s general practitioner said that she recalled being told about that matter and being *"taken aback"* by it. She said that she had never heard anything like that before from Mrs. Z and confirmed that, if she had, it would have been recorded in her notes. Z.Z.'s general practitioner could not recall whether the episode which had been related to her was historical or recent in nature.

- 7.40 During Z.Z.'s general practitioner's evidence, it was asserted on behalf of Mrs. Z that she never had that consultation on 22nd February, 2012 or the conversation as recorded by Z.Z.'s general practitioner. She, however, confirmed that, as far as she was concerned, the entry of 22nd February, 2012 was an accurate recording of the consultation.
- 7.41 Subsequent to Z.Z.'s general practitioner's evidence, her solicitors wrote to the Commission by letter of 15th February, 2019 enclosing (i) an extract from her logbook relating to appointments on 22nd February, 2012, with an appointment logged in respect of "[Z.Z.]", and (ii) a letter from a pharmacy in Family Z's local town attaching a copy of a "*script prescribed by [Z.Z.'s general practitioner]*" and which was in respect of Z.Z. This was dispensed at the pharmacy on 22nd February, 2012. The script itself recorded 22nd February, 2012 as the "*date prescribed*" and it included three medications, including "*resolor*", which is a medication used to treat symptoms of chronic constipation.
- 7.42 The Commission furnished these documents to Mrs. Z's solicitors for comment. They replied, stating that while Mrs. Z could not specifically recall attending Z.Z.'s general practitioner on 22nd February, 2012, she accepted that she "*may have presented to [Z.Z.'s general practitioner] with [Z.Z.] on that date for an appointment given that [Z.Z.'s general practitioner] was the family doctor at that time*". They stated that, if that had happened, it would have been for "*other health issues*", although the issue of sexual abuse might "*possibly have been discussed again around that time given that there were Garda investigations into this matter ongoing as well as the Conal Devine Report at that time*" (their emphasis). They reiterated Mrs. Z's position that she first brought her concerns regarding the issue of sexual abuse to Z.Z.'s general practitioner in the early 1990s and stated that she rejected Z.Z.'s general practitioner's evidence that she first heard about Z.Z.'s alleged abuse in February, 2012.
- 7.43 In his evidence to the Commission, Mr. Z said that his wife told him about the incident but did not know when it was that he was told, saying he was "*a small bit hazy*" on it. She told him that there was "*a suspicion*" over Z.Z. He did not think that she went into detail, explaining that their relationship was "*fairly fraught*" at that stage. He said that all he could say was that there was a question mark about Z.Z.'s "*being interfered with*", but could not recall when he was told about that. He was unable to assist the Commission as to details of

the bringing of Z.Z. to her general practitioner. He did not remember anything about a visit to the Mercy Hospital. Nor did he recall his wife's later meetings with Ms Doyle in early January, 1993 and he did not know if she had told him about that at the time.

Examination of Z.Z. in the Mercy Hospital

- 7.44 Mrs. Z said that after a telephone call to Consultant A, within days he arranged for a gynaecologist colleague of his, Consultant B, to examine Z.Z. in the Mercy Hospital in Cork. The issue that then arose for the Commission, having regard to Z.Z.'s medical records from the Mercy Hospital, was whether such an examination had taken place and, if so, when.
- 7.45 Mrs. Z believed that the examination took place in early December, 1992, indicating that it would have been the week after 8th December, 1992 and *"before the middle of December..."* She said that after the examination occurred, Consultant A emerged from theatre and told her that, in Consultant B's opinion, Z.Z. had not been *"breached"* but there might have been *"a little bit of bruising"*. Mrs. Z said that she did not speak to Consultant B.
- 7.46 Mrs. Z confirmed that Z.Z. had only gone to see Consultant B in relation to the sexual aspect of matters on one occasion. The medical records for Z.Z. from the Mercy Hospital show that she was admitted on 19th April, 1991 for elective gastroscopy and jejunal biopsy. She was discharged the same day and a note in the chart recorded that she was to be re-admitted on 23rd April, 1991 as a day case for an EUA (examination under anaesthetic). The records show that Z.Z. was re-admitted on 23rd April, 1991 and this gynaecological examination was carried out by Consultant B.
- 7.47 There were two letters addressed to Z.Z.'s general practitioner, both from Senior House Officers in the Mercy Hospital. One was dated 6th May, 1991 and related to test results regarding Z.Z. The other of 29th April, 1991 referred to Z.Z.'s admission to the Mercy Hospital for elective gastroscopy and jejunal biopsy, and stated that *"She had an EUA under [Consultant B], which showed an intact hymen and normal developing female introitus and there was no evidence of trauma."* A handwritten note made by Consultant B in the medical

records, dated 23rd April, 1991, stated “*E.U.A. N. developing ♀ introitus with intact O hymen No evidence of old trauma*”.

- 7.48 When Z.Z.’s general practitioner was asked if she had referred Z.Z. for the above procedures in April, 1991, she said that it was not recorded in her notes and she did not recall. She indicated that prior to receiving documentation from the Commission, she was unaware of Z.Z.’s having been seen by Consultant A and Consultant B in April, 1991. However, she accepted that records from the Mercy Hospital recorded her as being the referring doctor in relation to the admission on 19th April, 1991 for the elective gastroscopy and jejunal biopsy.
- 7.49 The medical records indicated that the gynaecological examination of Z.Z. took place in April, 1991 and not December, 1992. When this was put to Mrs. Z, she said that she did not know but believed it took place in December, 1992.
- 7.50 There was no reference in the Waterford Day Unit’s notebooks to Z.Z.’s attending hospital in December, 1992. There was a reference in the notebooks for 19th April, 1991 indicating that she had gone to a different hospital for investigation for coeliac disease. Mrs. Z confirmed that Z.Z. had been investigated for coeliac disease in April, 1991.

Attendance at the Waterford Day Unit

- 7.51 In describing these events as having occurred in December, 1992, Mrs. Z gave evidence that after attending Z.Z.’s general practitioner arising out of the incident with Z.Z. and before she attended the hospital with her, she went to the Waterford Day Unit either that Monday evening or the following Tuesday morning to discuss what had happened with Sr. Sigma and the staff. She said she met with Sr. Sigma, Day Unit Worker 2 and Day Unit Worker 3 and told them what had happened and she told them that Z.Z.’s general practitioner thought that Z.Z. had been “*breached*”. She said that she told Day Unit Worker 2 about what she had said to Z.Z. and how she had behaved. Mrs. Z said that Day Unit Worker 2 then took Z.Z. into another room and, when she returned, she nodded to Day Unit Worker 3 and Sr. Sigma. In Garda statements made in 2013 and 2016, Mrs. Z had said that, when she told Day Unit Worker 2 what had happened at home with Z.Z., Day Unit Worker 2 had taken Z.Z. into the

room at Sr. Sigma's request and uttered the same phrase which had triggered the behaviour at home, resulting in the behaviour's being repeated.

- 7.52 Mrs. Z's memory was that, at some point, Sr. Sigma told her she would investigate the Unit staff and the staff who ran the ambulance which was used to transport Z.Z. to and from the home of Family X and the Unit along with other disabled children.
- 7.53 In giving evidence to the Commission, neither Day Unit Worker 2 nor Day Unit Worker 3 were able to recall the conversation that Mrs. Z said she had had with the Unit staff nor could they recall being told of the doctor's view that Z.Z. had been "*breached*". They did not recall any investigation having been carried out by Sr. Sigma on foot of the alleged abuse of Z.Z.
- 7.54 Day Unit Worker 2's evidence was that she did not remember taking Z.Z. into a room or being asked to do so by Sr. Sigma for the purpose of repeating the phrase which gave rise to the incident at home. Day Unit Worker 3 had no recollection of that either. Day Unit Worker 2 said "*...I don't believe I would have put a vulnerable child through that, no. I don't think -- I don't remember that, no*".
- 7.55 There was no reference in the Waterford Day Unit's report of 12th January, 1993 to such a conversation or incident in the Unit.
- 7.56 The evidence given by the staff of the Unit does not support Mrs. Z's memory of the incident with Z.Z. as having occurred in December, 1992. The Commission is not satisfied that Mrs. Z told Sr. Sigma, Day Unit Worker 2 and Day Unit Worker 3 of such incident or that she told them that Z.Z.'s general practitioner said Z.Z. had been "*breached*". The Commission is not satisfied that Day Unit Worker 2 took Z.Z. into a room in the Unit, as described above.
- 7.57 Mrs. Z was clear in her evidence that Z.Z. underwent a gynaecological examination on one occasion only.
- 7.58 The only documentation available to the Commission in respect of that gynaecological examination of Z.Z. was for 1991. The Commission is not satisfied that an examination of this type occurred in December, 1992.

- 7.59 While the Commission does not doubt that the behaviour witnessed and described by Mrs. Z and her neighbour, Mrs. T, occurred, it cannot be satisfied that it occurred in December, 1992. The Commission also cannot be satisfied that what is said to have flowed from the alleged incident, namely that Mrs. Z spoke with Mrs. T, brought Z.Z. to Z.Z.'s general practitioner, alerted the Waterford Day Unit staff, and brought Z.Z. to Consultant A, where she was examined by Consultant B, occurred at that time, December, 1992.
- 7.60 The Commission is satisfied, on the basis of the records made by the Waterford Day Unit in relation to Z.Z. during her time with Family X, on the one hand, and on the evidence of Mrs. Z, Ms Doyle and the staff who were involved with her at that time, on the other, that there were concerns about her, covering such matters as her diet, unaccounted for injuries and her overall presentation, as well as the *"new behaviours"* described by Day Unit Worker 2.
- 7.61 The Commission is also of the view that there were sufficient concerns in April, 1991 as to lead to Z.Z.'s undergoing a gynaecological examination by Consultant B in the Mercy Hospital Cork. No evidence has emerged before the Commission that the circumstances surrounding this examination were brought to the attention of the health board in 1991.

Ms Doyle's notification of concerns to South Eastern Health Board

- 7.62 The key development for the purpose of the initiation of the health board's investigation, which will be dealt with below, was the communication of the Unit's concerns to Ms Doyle, as referred to above at paragraph 7.19.
- 7.63 Ms Doyle wrote to Dr. Walsh on 22nd December, 1992, stating:-

"Dear Dr. Walsh,

I write to inform you that concern has been expressed by staff in the [Waterford] Day Unit about a young girl placed with Mr. and Mrs. [X], [Address]. I understand that she has been placed on a private basis but due to concern expressed by her mother has now removed her.

*I have asked them to prepare a report and forward same to you.
We will discuss this at our planned meeting in January.*

Wishing you a Merry Christmas and Happy New Year."

Meetings between Mrs. Z and Ms Doyle in 1993

- 7.64 Around this time, early January, 1993, Ms Doyle had three meetings with Mrs. Z, after which she wrote, as set out below, to Dr. O'Boyle on 14th January, 1993. It appears that Sr. Sigma told Mrs. Z that she had contacted Ms Doyle. Mrs. Z then requested to meet with Ms Doyle. The meetings took place in Ms Doyle's offices in Lisduggan Lodge.
- 7.65 With regard to the substantive content of their discussions, Mrs. Z said that it was *"really about placement"*. She said that they conversed about *"a lot of things, such as home and family and [Ms] Doyle was informed of the situation with [Z.Z.] at the time"*. She said that she thought that Ms Doyle told her that *"she would ask members of the HSE to look for alternative accommodation for [Z.Z.] and that it was urgent"*.
- 7.66 Mrs. Z said that she made a complaint to Sr. Sigma and Day Unit Worker 2 regarding Z.Z.: *"I had put in a complaint about [Family X] as such and the neglect of [Z.Z.] and the sexual abuse that I believed took place"*. Mrs. Z told the Commission she could not remember making an actual complaint to Ms Doyle, saying *"I don't remember that but we had lots of discussions about that"*.
- 7.67 For her part, Ms Doyle's recollection of these meetings was of Mrs. Z's being very upset and quite distressed and that, living such a long distance from the Waterford Day Unit, she had to travel to access a service for Z.Z. Ms Doyle was sensitive to the pressures on Mrs. Z and her reluctance to end the placement with Family X, saying *"this arrangement was in place in order to facilitate [Z.Z.] to continue to attend the [Unit] and not have that long journey and difficult journey"*. At the time she saw her, she said that she was *"under considerable pressure and she was very concerned about what she was now going to do in relation to [Z.Z.] continuing the [Unit] and getting the care and support that she needed"*.

7.68 Ms Doyle remembered Mrs. Z's telling her that Z.Z. had been seen by a paediatrician in Cork in 1991. Asked if she could recall if she told her why that was, she said "[m]ore precisely I don't recall..." She confirmed that this could only have been conveyed to her by Mrs. Z in January, 1993. She did not recall her raising it as a sexual issue with her. Asked what her reaction would have been if she had learnt at that stage that she had seen a paediatrician in connection with a sexual concern, she said that she *"would have understood that there was concern about sexual abuse because there had been a vaginal discharge"* and that she would have notified it to the health board, *"as I encapsulated in my report"*. She said that her concern about any sexual issue was related to the vaginal discharge, saying, *"yes, yes and only that, that would have been the only information I had"*.

7.69 Ms Doyle described her letter of 14th January, 1993 to Dr. O'Boyle as a *"summary report effectively"*, referencing her discussion with the Waterford Day Unit staff before Christmas 1992 and her meeting with Mrs. Z around that time. With regard to the passage in her letter which stated that *"[c]oncern was also expressed about sexual abuse as [Z.Z.] was observed with vaginal discharge in May 1991"*, Ms Doyle said her memory was that she would have received that information from the Waterford Day Unit. She told the Commission that that was reflected in the fact that at a meeting on 15th January, 1993, (with health board officials discussed below), this concern had been queried with her because it was not in the Unit's report. She told the Commission that she thought it likely that Mrs. Z had spoken to her about concerns that had arisen on that date in 1991. Ms Doyle said that, *"at the meeting itself I would have referenced the fact that [Z.Z.] had been seen by a paediatrician in Cork"* and her memory was that Mrs. Z had told her that. She appeared to believe that the reference to concerns about sexual abuse and vaginal discharge were mentioned by the Waterford Day Unit staff but that Mrs. Z would also have mentioned that and referred to a visit to a paediatrician.

7.70 Ms Doyle was not told about any episode with Z.Z. at home.

Ms Doyle contacts Dr. O'Boyle

7.71 Arising out of all the information which came into her possession, Ms Doyle wrote a letter about Z.Z. to Dr. O'Boyle on 14th January, 1993, which was

entitled “*Social Worker’s Report*”. The report displayed an acute awareness of the pressures on Mrs. Z in trying to ensure continued attendance by Z.Z. at the Waterford Day Unit and was sensitive to her concern that ending the care arrangement for Z.Z. would place strain on her marriage. The letter was copied to Dr. Walsh and Sr. Sigma and, later, to Mr. Conaty.

7.72 In the report, Ms Doyle said:

“I have met with Mrs. [Z] on three occasions in the past week as a result of concern expressed about [Z.Z.’s] five day placement, on a private basis, with Mr. & Mrs. [X] of [Address].

[Z.Z.] attends the [Waterford Day Unit] since September 1990. She has been placed on a five day basis with Mr. & Mrs. [X]. This is a private arrangement between [Family X] and Mrs. [Z], a service for which Mrs. [Z] has been paying on a weekly basis. Ms. [Z] indicates that this arrangement was initially organised as a result of her need for admission to hospital and subsequent recovery on discharge. By December of that year, Mr. and Mrs. [X] indicated a wish to maintain the arrangement and Mrs. [Z] agreed, feeling that it resolved some of the difficulties that existed in transporting [Z.Z.] to and from Dungarvan each day to meet with the school transport. Mrs. [Z] also indicates that her husband has never taken responsibility for the care of [Z.Z.] and at that time was indicating, as he continues to do so, a desire to have [Z.Z.] placed in seven day care. I understand from her that this situation has caused severe marital difficulties in the past and she felt that the arrangement with [Family X] would alleviate the general situation.

It emerged from my discussion with staff members in the [Waterford Day] Unit just prior to Christmas, that they have been concerned about [Z.Z.’s] placement with [Family X] on and off during this time. They indicated that her level of physical care and hygiene has decreased considerably; her diet has not been adhered to, which results in behaviour management with [Z.Z.]; and on occasions [Z.Z.] has been observed with physical marks

that have not been fully explained. Concern was also expressed about sexual abuse as [Z.Z.] was observed with vaginal discharge in May 1991. I understand that all of these concerns were discussed with Mrs. [Z] by Unit staff and as this was a private arrangement, she was encouraged to discuss the situation with Mr. & Mrs. [X].

It is important to note here that all of the above concerns are allegations which were not investigated and therefore have not been validated. I also feel, from discussion with Mrs. [Z], that many of these concerns were not discussed with [Family X] as she felt this would jeopardise [Z.Z.'s] placement with them.

As a result of discussion with Unit staff prior to Christmas, Mrs. [Z] removed [Z.Z.] from the care of Mr. & Mrs. [X]. However she did not indicate her precise reasons for doing so, but rather suggested that [Z.Z.] was not well and would be better to remain at home. However [Z.Z.] was in the care of [Family X] for two days during the Christmas period, at which time Mrs. [Z] hinted that she may not be continuing the arrangements as the family's financial situation was becoming untenable.

On 4.1.1993, I met with Mrs. [Z] and indicated to her the seriousness of the situation and the need for [Z.Z.'s] welfare to be considered paramount. On the one hand I understand Mrs. [Z's] reluctance to finish this arrangement as she feels there will be untold marital difficulties and she doesn't feel that she will be able to transport [Z.Z.] on a 23 mile round trip to meet with school transport twice a day. However on the other hand, I fail to see how she has continued with this arrangement, given her knowledge and her own concerns that [Z.Z.] has, on occasions, not been cared for very well.

Mrs. [Z] has now decided that [Z.Z.] will not return to [Family X]. She has spoken to them but has not indicated at any level, her reasons for removing her.

I shall discuss this case at the forthcoming meeting arranged with Health Board Personnel to review the placement of children with Mr. & Mrs. [X]. I have requested [Waterford] Day Unit staff to prepare a report which I hope will be available for this meeting. I feel that alternative placement of [Z.Z.] needs to be acquired as a matter of urgency. Her long term placement needs ought to be examined. However in the short term, I feel that five day fostercare, perhaps within Waterford City area, would be sufficient to meet her needs as she could continue to attend the [Waterford] Day Unit. Mrs. [Z] is aware of this forthcoming meeting and has requested me not to discuss [Z.Z.'s] case. However I have indicated the gravity of the situation and furthermore the need to outline this family's needs so that alternative placement can be secured."

7.73 Dr. O'Boyle said that he understood the reference to a forthcoming meeting with health board personnel as being to a case conference. He did not think that he knew anything about it before he received Ms Doyle's letter. Dr. Walsh and Ms O'Sullivan told the Commission that it was not a case conference but a "*professionals' meeting*". Dr. Walsh said that its purpose was to gather the professionals together prior to setting out a plan for carrying out an investigation.

7.74 Importantly, Dr. O'Boyle agreed that the letter raised concerns about a possible instance of child abuse. His views on that were mirrored by Dr. Walsh who, although she could not remember receiving the letter, accepted that she had and acknowledged that it raised "*serious concerns*" which, if accurate, came within the ambit of the definitions of child abuse / child sexual abuse. Dr. Walsh agreed that taking that letter and the Unit's report together, they warranted the carrying out of an investigation by the health board.

Mrs. Z's concern about discussion of Z.Z.'s case

7.75 Ms Doyle's letter indicated that Mrs. Z was aware of the forthcoming meeting with the health board and had requested her not to discuss Z.Z's case, something Mrs. Z agreed she might have said. Asked if that reflected her view at the time, she said "*I suppose it was a very private matter to me at that stage,*

to be honest, and who was going to be at that meeting...that is a very personal thing as such". She acknowledged that she gave Ms Doyle the impression that she did not want Z.Z.'s case openly discussed or that she was reluctant for that to happen. Explaining her position, she said, *"I think you have to remember the place I was in at that time, you know, I was in a very vulnerable position at that stage and my whole family were being torn apart by it...I didn't want everybody to know our business".*

7.76 While Mrs. Z did not want Z.Z.'s specific case discussed, she did want the concerns about Family X to be looked into and Mr. Conaty's evidence was that he could sometimes carry out investigations on foot of complaints made by people who did not want their names disclosed.

7.77 Ms Doyle took her own position on whether concerns about Z.Z. should be raised with the health board and, as will be seen below, went on to raise her case at the meeting on 15th January, 1993. She said *"I would have felt that the concerns that had been raised merited notification to the health board to be assessed as child welfare concerns".* She said that it was entirely a matter for herself to ensure that they were reported.

Z.Z.'s removal from Family X

(i) Pre-Christmas

7.78 The Unit's concerns about Z.Z.'s case had been brought to Mrs. Z's attention by this stage. She told the Commission that she was desperately upset. Mrs. Z could not recall whether there was any contact between her and Mrs. X around this time or whether she gave her any reason for removing Z.Z. at this point.

(ii) Post-Christmas

7.79 In Ms Doyle's report dated 14th January, 1993, she had stated that Z.Z. had been in the care of Family X for two days during the Christmas period. This occurred after Christmas, around 8th to 11th January, 1993. In relation to removing Z.Z. from the placement in January, 1993, she said that she told Mrs. X *"that financially we couldn't afford it any more".*

- 7.80 In this regard, Mrs. Z was under considerable pressure to have a place for Z.Z. at that time. She explained to the Commission, *“I know maybe it was selfish of me to put her back but when there was no proof that she had been abused vaginally I felt that she would be okay for a little while until I got myself sorted out and other arrangements made because [Ms Doyle] was really adamantly looking for another placement in Waterford City at that time”*.
- 7.81 Mrs. X did not have an accurate recollection of when the arrangement ended. She did not remember Mrs. Z’s telling her that she could not afford to have Z.Z. with her anymore. Mrs. X’s recollection as to why the placement ended was because the house was not good enough.
- 7.82 Mrs. Z said that she possibly discussed Family X’s house with Sr. Sigma but that this would have been in the way of a comment rather than a complaint. In her evidence she referred to *“steep stairs”* in Family X’s house and the difficulty they posed to someone like Z.Z. with disabilities and poor balance. She said that she had no choice but to go there.

Mr. Conaty’s preliminary analyses

The position of Z.Z. within the Family X Household

- 7.83 The Waterford Day Unit’s report and Ms Doyle’s letter to Dr. O’Boyle both came to Mr. Conaty’s attention. On 13th January, 1993, Dr. Walsh sent the report to Mr. Conaty so that, she said, he could assess the allegations in his capacity as the Senior Social Worker and the service manager for child protection and welfare concerns.
- 7.84 Dr. O’Boyle could not recall if the report ever made its way to him and did not know if he had seen it before he received it from the Commission. However, looking at the report during his evidence and the nature of the complaints outlined in it, particularly where there was a note that no explanation had been offered for them, Dr. O’Boyle thought there was *“cause for concern”*, and agreed that the regularity of occurrence of these complaints could point to a more serious underlying difficulty.

- 7.85 Mr. Conaty explained to the Commission that the previous Director of Community Care had directed him to gather all information possible, bring it to his attention and report to him in relation to any allegation of abuse or neglect. Referrals to the health board about neglect and such matters, the bulk of which came from members of the public and public health nurses, would be reported to him and he would usually carry out an investigation into them. He did not necessarily think that his own responsibilities gave him any particular expertise in carrying out such investigations, indicating that there was no proper expertise in the South Eastern Health Board at the time.
- 7.86 Mr. Conaty had no real recollection of the information conveyed in the Waterford Day Unit's report being brought to his attention. He said that he analysed it when he received it and made some notes on it. Beside the paragraph (beginning with *"Other areas of care..."*), he had marked *"NB"* because, he said *"the whole welfare of the child is at stake there"*. Mr. Conaty told the Commission that *"the child's welfare was sticking out a mile"*. He said that the suggestion of unkemptness, poor hygiene and matted and unwashed hair needed to be looked into as did, indeed, *"the whole area"*.
- 7.87 Mr. Conaty displayed a sceptical attitude towards referrals of suspected abuse or neglect. During his evidence, when discussing referrals of abuse or neglect made by persons who did not wish to be identified, he initially said that *"...very often you could sort the thing out without naming names at all. Nine times out of ten [such complaints] could have been malicious"*. Mr. Conaty went on to say that this applied to one out of two complaints, saying he was working *"from memory"*. He said that he did not approach investigations from the point of view that complaints were malicious until proven otherwise. He said that *"Nine times out of ten it was going back to some domestic matter"* and said it *"seemed"* like ninety *per cent* at the time.
- 7.88 Mr. Conaty's initial considerations were reflected in a number of annotations and underlining of certain parts of Ms Doyle's letter to him. He did this within a day or so of receiving it. He explained that the various underlined parts, in his opinion, indicated a lack of consistency on Mrs. Z's part with regard to Z.Z. and the concerns about her care by Family X. He said that *"it looked as though they [Family Z] were saying she wasn't well, yet they were sending her back to [Family X] for Christmas"*.

- 7.89 Thus, he considered the fact that Z.Z. had been sent back to Family X to be inconsistent with the claim that she had been removed because she was unwell. He told the Commission that he thought that if Z.Z. was sick she would have been at home.
- 7.90 He also made an annotation on the report with respect to the concerns raised by the Unit staff which read “...*concerns not considered by parents to be so grave as to warrant total removal*”.
- 7.91 Mr. Conaty said that Mrs. Z’s continuation of the arrangement with Family X, notwithstanding her own knowledge and concerns for Z.Z., also struck him as incongruous. He said that it “*didn’t add up*” and reiterated that if Z.Z. was unwell, she should have been at home, pointing out, moreover, that it was Christmas.
- 7.92 Mr. Conaty also formed the view that the fact that Mrs. Z did not give any reasons to Family X for removing Z.Z. was of note. In this regard he said to the Commission, “[w]ell *I would have thought it was common courtesy she would tell [Family X]*”. This was an unusual observation having regard to the circumstances as outlined to Mr. Conaty in Ms Doyle’s report. Reading between the lines, as he put it, he thought that Mrs. Z was not coming clean with Family X and that her behaviour was, once again, inconsistent. He said, “[s]he *is not speaking well of them one day, she couldn’t speak highly enough of them the next*” and “*here she’s putting the child in one day, taking it out, putting it back. There’s very poor consistency...*” Mr. Conaty told the Commission that he viewed that as a matter of concern and something of importance in carrying out his investigation.
- 7.93 Mr. Conaty characterised Mrs. Z’s request that Z.Z.’s case not be discussed at the impending meeting with the health board as a “*change of mind*”. He told the Commission, “*it seems to me that she wanted everything on the child’s side, whether it be in the child’s best interest or not. She is speaking highly of [Family X] and yet she doesn’t want the child to go back to them*”. He described himself as being “*lost in the middle*” of that and asked, rhetorically, what was one supposed to do. Mr. Conaty’s view was that Mrs. Z was making a complaint but was not prepared to follow it through. He told the Commission that the letter from Ms Doyle did not mention where Z.Z. was actually happy, saying, “*Is the*

child happy with [Family X]? Is the child happy in the [Waterford] Day Centre? Is the child happy at home with the mother?" He said that it appeared to be "going around in circles".

- 7.94 Mr. Conaty said that he had highlighted any inconsistencies "[f]or anybody else reading it, if they took the file out and read it, they were concerns I had". However, Mr. Conaty agreed that his annotations appeared to be part and parcel of the investigation he was carrying out as opposed to notes for the benefit of someone else.

The position of Grace within the Family X household

- 7.95 Mr. Conaty told the Commission that he could not recall if he spoke to Ms Greaney about Grace's presence in Family X's house before he started visiting anyone. Mr. Conaty acknowledged that, in conducting his investigation, he had not attached any importance to the fact that Grace was living in the house, having been placed there by the health board while a child in the board's care. He did not have any regard to the relevance of this in conducting his investigation. Mr. Conaty agreed that he did not view the investigation from Grace's perspective, saying that he was not dealing with her. He told the Commission that he could not recall why that was. He confirmed that his intention in carrying out his investigation was limited to considerations of Z.Z. and her welfare.
- 7.96 As to whether any allegation of impropriety as against Family X might well have an effect on Grace and require the South Eastern Health Board to consider her placement, Mr. Conaty said that "*it was something you always keep in the back of your mind*". However, to the best of his recollection, he "*had no reason to doubt anything*" at the time and, while acknowledging that he might have kept all of this at the back of his mind, he said that any such consideration was not the driving force in connection with the investigation he was conducting.

Meeting of 15th January, 1993 - Ms Doyle and health board officials

- 7.97 On 15th January, 1993, the meeting requested by Ms Doyle was held, attended by herself, Mr. Conaty, Dr. Walsh, Ms Greaney and Ms O'Sullivan.

- 7.98 Arising out of Ms Doyle's letters of 2nd and 22nd December, 1992 to Mr. Conaty and Dr. Walsh respectively, there were two items for discussion, namely Family X's taking private placements and her view that the health board should be aware of that, and the concerns communicated by the Waterford Day Unit about Z.Z. The meeting also had to hand the report of the Waterford Day Unit of 12th January, 1993 and Ms Doyle's letter to Dr. O'Boyle of 14th January, 1993.
- 7.99 This was an important meeting as it gave the health board officials an opportunity to meet with and ask questions of Ms Doyle, who was communicating concerns about Family X in two important respects, particularly on the concerns communicated by the Waterford Day Unit in respect of Z.Z.

Mr. Conaty's notes of the meeting

- 7.100 Mr. Conaty made handwritten notes of the meeting and later prepared a typewritten report for Dr. O'Boyle. Parts of his handwritten notes were crossed out by him and his typewritten report differed from them in a number of material respects. The Commission received evidence from Mr. Conaty to explain how these differences arose.
- 7.101 According to crossed out portions of his handwritten notes, Ms Doyle informed those present that Z.Z. had been seen by a paediatrician in Cork for *"?vaginal infection + sexualised behaviour, result allegedly NAD [nothing abnormal detected]"*. This referred to the visit to the paediatrician in April, 1991. In further crossed out portions of his notes he recorded her as saying that Family X took children and adults privately without notifying anyone which, he noted, *"would not be in keeping with the Boarding Out Regulations as implemented by the [health board]"*.
- 7.102 While Mr. Conaty acknowledged that what he had recorded in those respects was important, he could not recall or explain in his evidence why he had crossed them out and also omitted them from his report to Dr. O'Boyle. Bearing in mind Dr. O'Boyle's evidence that it was unlikely that he received Mr. Conaty's handwritten notes, it appears to the Commission that this was a significant omission and that Dr. O'Boyle did not receive a full account from Mr. Conaty of the concerns being raised in respect of Z.Z. in the Family X placement.

- 7.103 Ms Doyle told the Commission that the concerns she brought to the meeting were “*very important*”. At the meeting, the health board officials asked her about the reference to vaginal discharge, given there was no mention of it in the Unit’s report, and she recalled that she explained that Mrs. Z had talked about it to her. While she could not remember who had mentioned the “*sexualised behaviour*”, it is considered likely that it was raised by Ms Doyle, given her earlier discussions with Day Unit Worker 2, the content of the Unit’s report, and her discussions with Mrs. Z.
- 7.104 Ms Doyle said that the concern about Family X’s taking children and adults privately without notifying anyone related to her letter to Mr. Conaty of 2nd December, 1992. However, she did not recall referencing incompatibility of that with health board regulations, stating that she thought “*it would have been more a query as to whether [Family X] would need to let the health board know given that they had children placed with them in care*”.
- 7.105 The meeting also heard about Z.Z.’s removal from Family X and of her brief return there over the Christmas period. Mr. Conaty’s notes recorded that Z.Z. continued to stay with Family X and that Mrs. Z had told Ms Doyle that it was “*either that or her marriage*”. Referring to the meeting in his report to Dr. Boyle, he referenced this and characterised the ostensible basis for her brief removal, *i.e.* “*financial reasons*”, as “*an excuse and...in fact a lie to [Family X]*”. He noted in his report that, according to Ms Doyle, when Mrs. Z returned Z.Z. to Family X over the Christmas period, she did not express any direct concern to them or want the matter to go any further. She continued to leave Z.Z. there as it was the only option she had, a state of affairs which, as Ms Doyle noted in evidence, was reflected in her letter to Dr. O’Boyle.
- 7.106 In his account of the meeting in his final report to Dr. O’Boyle, Mr. Conaty stated that “*having listened to the entire situation surrounding the concerns it appeared on the face of it that the concerns raised posed the question of quality of care as opposed to any form of neglect*”. Ms Doyle could not recall this being a conclusion at the meeting. Instead Ms Doyle told the Commission that, as she understood it at that time, the concerns she raised were being assessed and investigated. In fact, Mr. Conaty confirmed to the Commission that this remark appeared to be his own.

- 7.107 A sceptical attitude by Mr. Conaty was again apparent from his observation in his report to Dr. O'Boyle that, in the light of the timespan of events outlined in the Waterford Day Unit's report, it *"seemed also to raise the question that if there was so much concern why was it left to such a late date to be brought to our attention"*.
- 7.108 In his report, Mr. Conaty also referred to a *"recognition"* that Family X were not getting any younger and that they might be *"putting themselves under undue pressure in their efforts in caring for children who, to say the least, are extremely demanding"*. He recalled in his evidence that Mr. X seemed a bit breathless and Mrs. X, while reasonably active, sat in an armchair most of the time he was there. He told the Commission, *"I just couldn't help feeling that the demands of mentally handicap[ped] children on two elderly people were too much."*
- 7.109 Mr. Conaty noted the consensus of opinion at the meeting as being that he contact Sr. Sigma regarding the content of the Unit's report. Meanwhile, he was to discuss the matter with Ms Greaney with a view to visiting Sr. Sigma and, eventually, Family X.
- 7.110 Ms Doyle also recalled that as being the outcome and considered her role to be at an end. Neither Dr. Walsh nor Ms O'Sullivan had any recollection of the meeting or what was discussed at it.
- 7.111 There is nothing to indicate that the meeting decided that the suggestion that Family X was not notifying appropriate health board personnel of private placements should be investigated by Mr. Conaty, nor is there any evidence that he undertook any such investigation of his own accord.
- 7.112 It appears to the Commission that it would have been important for Dr. O'Boyle, as Acting Director of Community Care / Medical Officer of Health, and the health board to be aware as to whether Family X was accepting private placements at a time when they had Grace as a health board placement, something acknowledged by Mr. Conaty in his evidence. It was recognised at the meeting that the ages of Mr. X and Mrs. X and the demands of the children they were caring for were potentially placing undue pressures on them.

Mr. Conaty's meeting with the Waterford Day Unit

- 7.113 On 28th January, 1993 a meeting was held at the Waterford Day Unit, attended by Mr. Conaty, Ms Greaney, Sr. Sigma, Day Unit Worker 1, and Day Unit Worker 2. This followed his request for a meeting contained in a letter he wrote to Sr. Sigma on 18th January, 1993. This meeting was an opportunity for the health board officials to meet with the persons who were interacting with Z.Z. on a more or less daily basis. The persons attending were well placed to clarify if her appearance and behaviour had changed since staying with Family X.
- 7.114 Due to Mr. Conaty's death the Commission was unable to take his evidence on his account of this meeting.
- 7.115 Documents made available to the Commission show that Mr. Conaty made short handwritten notes of the meeting, containing brief comments on various records in the Unit's report. His account of the meeting in his typewritten report to Dr. O'Boyle was in similar vein and stated that the Unit's report had been gone through "*in full detail*". Beyond that, his records of the meeting did not give any indication of what, if any, questions were posed by him at it or outline the interaction between the attendees. Nor did they contain any references to the entries for April or September, 1991 in the Unit's report which concerned such matters as the "*new behaviours*" and Z.Z.'s reluctance to leave after weekends at home.
- 7.116 Day Unit Worker 1 told the Commission that the meeting lasted at most one hour and that Mr. Conaty had taken the lead at it. Day Unit Worker 2 had no recollection of what happened at the meeting.
- 7.117 Day Unit Worker 1 told the Commission that her feeling was that both Mr. Conaty and Ms Greaney thought that the Waterford Day Unit was being "*over fussy*". She said, "[t]hat was my sense from that meeting with Mr. Conaty and with [Ms] Greaney, more particularly from Mr. Conaty". It appears that he did not say anything specific to that effect and that it was "*just his method of questioning*". While she could not remember the detail of the meeting, she said that she "*felt that the finger was being pointed back at us*" by Mr. Conaty.

7.118 Explaining why she had that feeling, Day Unit Worker 1 said, “[i]f there was a little bruise sort of somewhere, and I said the staff were absolutely meticulous in terms of collating and reporting, absolutely meticulous, if somebody noticed, for instance, a little bruise to a finger they would write that down and they would report it to parents, or whatever, you know, finger struck a door, whatever. But he, it was like, you know, every time that happened call a GP in, so it was kind of lobbed back to us, and that is the sense I had with that meeting, it was kind of defensive.”

Ms Doyle’s letter to Dr. O’Boyle – 27th January, 1993

7.119 On 27th January, 1993, Ms Doyle sent a report to Dr. O’Boyle about Z.Z., which she had prepared on 21st January, 1993. She advised that she had met with Mrs. Z on that date in Lisduggan Lodge and found her to be upset and quite distressed, having been told by Z.Z.’s bus driver that he would no longer be in a position to provide her with transport due to her difficult behaviour. Ms Doyle described the situation as “*very serious*” and that a breakdown of the transport arrangement would result in Mrs. Z’s either making a “*106 mile*” daily round trip to convey Z.Z. to the Unit or keeping her at home, which she said would “*place a severe strain on the family*”. She stated that it was precisely that situation which had led Mrs. Z to continue with the arrangement with Family X despite having some reservations and concerns.

7.120 Ms Doyle explained in her letter that Mrs. Z had made further inquiries about residential care for Z.Z. but was “*not hopeful of a positive outcome*”. She also informed Dr. O’Boyle that she had told Mrs. Z about the meeting with health board officials on 15th January, 1993 and that Z.Z.’s current situation had been discussed at it, with the possibility of further discussion about the concerns about her placement with Family X. She said that she reassured Mrs. Z that every attempt would be made to secure as an “*utmost priority*” an alternative five-day placement for Z.Z. in the Waterford City area which, she said, would be investigated by Ms O’Sullivan. She emphasised that Mrs. Z was in a very difficult position and required “*all possible assistance*”.

7.121 The letter was copied to Dr. Walsh, Mr. Conaty, and Sr. Sigma. It also bore a note indicating that it was to be copied to Ms Greaney “*in light of previous reports and current investigation*.” It was not, however, copied to Ms O’Sullivan,

who told the Commission that she had no authority to place a child, whether it had disabilities or not, in foster care, and that nobody had ever asked her whether she could place Z.Z. anywhere along the lines suggested in the letter.

7.122 Ms Doyle said that her motivation in writing the letter was to show that Mrs. Z still needed support in relation to securing an alternative placement for Z.Z. so that she could attend the Waterford Day Unit.

7.123 Ms Doyle did not recall receiving any response to her letter from Dr. O'Boyle. Dr. O'Boyle, for his part, said that he did not remember receiving her letter and was unable to say whether there had been any action on foot of the issues raised in it.

Mr. Conaty's meetings with Family X and Family Z

7.124 The next steps in Mr. Conaty's investigations were to meet Family X and Family Z. His report to Dr. O'Boyle noted that he met Family X on 8th and 22nd February, 1993, and Family Z on 11th February, 1993. On all of these occasions he recorded that he was accompanied by Ms Greaney.

7.125 Due to Mr. Conaty's death the Commission was unable to take his evidence on his account of these meetings.

7.126 Mrs. X's recollection of meeting Mr. Conaty was poor and confused. She was only able to recall meeting him once, seemingly after he had met with Family Z. Nobody else was present apart from Ms Greaney. She thought that the meeting lasted about ten minutes, during which Ms Greaney effectively did the talking with Mr. Conaty sitting and listening. She did not recall him taking notes. She also said that she did not query what caused the visit, but later said that she asked them and that they declined to tell her.

7.127 The Commission is satisfied that both visits occurred. Mrs. X's evidence suggested that she recalled the meeting of 22nd February, 1993, inasmuch as her account of it referred to Mr. Conaty's and Ms Greaney's having already been with Family Z, which happened after Mr. Conaty and Ms Greaney had first visited Family X (see below). It may be that Mrs. X had forgotten the first

visit by the time she gave evidence to the Commission. As noted above, Mrs. X's evidence was confused on this issue.

Meeting of 8th February, 1993

- 7.128 Mr. Conaty made handwritten notes of this meeting and an account of it was contained in his report to Dr. O'Boyle. In that report, he recorded that he discussed the contents of the Waterford Day Unit's report with Mr. and Mrs. X, taking them through the matters identified in it and allowing them to comment on them. He recorded that they were "*baffled*" by the Unit's allegations, saying that there was a "*very amicable rapport*" between themselves and the Unit, especially Day Unit Worker 2. Day Unit Worker 2's evidence to the Commission on this aspect was that she only ever had contact with Family X twice, once when she brought Z.Z. back to their house, and on another occasion, when she received a telephone call from Mr. X.
- 7.129 Mrs. X disputed that Mr. Conaty had discussed the report with them and said that she had only learnt of its existence from the Gardaí subsequently during their investigation into alleged abuse of Z.Z. However she told the Commission that she did not remember their discussion and denied making statements recorded in Mr. Conaty's report as being attributable to her and her husband.
- 7.130 A number of examples serve to illustrate her evidence in this regard. For instance, Mr. Conaty's report recorded that he had discussed the "*new behaviours*" outlined in the Unit's report with her, but Mrs. X said that she had never heard about that before the Gardaí spoke to her.
- 7.131 His report recorded discussion about the notebooks which went between the Unit, Family X, and Family Z, and that Mr. and Mrs. X were adamant that any messages that came home in them were strictly complied with by them. His report also recorded that Mr. and Mrs. X requested of him that the notebooks in question be obtained. While Mrs. X said in evidence that no notebook existed for Z.Z. during the time she stayed with her, Mr. Conaty's report recorded that during his first meeting with Mr. and Mrs. X, he undertook to obtain a copy of the notebook in respect of Z.Z. to clarify the matters discussed. Mr. Conaty's action in relation to this request is referred to below.

- 7.132 Mr. Conaty's report also indicated that he discussed Z.Z.'s diet with Family X, who told him that it was strictly adhered to and that there was a diet list hanging in their kitchen. In evidence, however, Mrs. X told the Commission that she could not remember saying that and denied having such a list in the kitchen.
- 7.133 Mrs. X's evidence was very confused on the matters recorded by Mr. Conaty in relation to this matter. She had no recollection of conversations with him on many matters contained in his report. Notwithstanding that, the report also contained detailed information which, it appears, could only have come from Family X.
- 7.134 Thus, for instance, the Waterford Day Unit's report had recorded a bite-like mark and bruising on Z.Z. on a particular date. Mrs. X told Mr. Conaty that that date fell on a Monday (which was correct), when Z.Z. would arrive at the Unit from her home. She recalled that she had bathed Z.Z. the following day and not noticed any marks. Although Mrs. X said that she did not have such a conversation with Mr. Conaty, she did agree that he could not have got that detail from anybody else. The account recorded by Mr. Conaty was also consistent with her own evidence that Z.Z. used to come to her on a Monday evening.
- 7.135 Mr. Conaty's report also noted that when the account in the Unit's report of Z.Z.'s hair being matted and unwashed was raised with Mr. and Mrs. X, they said that Z.Z. had a habit of *"impulsively putting for example rice in her hair...and a habit of sucking her hair and at times spitting on her hands and then pushing her hair back up which would give the possible appearance of matted hair..."* Mrs. X said that Mr. Conaty did not learn this from her. This account was consistent, however, with evidence given by Mrs. X to the Commission. She agreed that it would have been *"very odd"* of Mr. Conaty to have recorded something like that – which, on her own account, actually happened – if she had not told him this at their meeting.
- 7.136 According to Mr. Conaty's record of the meeting, Mrs. X attributed some bruising to Z.Z. to her being on a tractor with her brother and her poor presentation to her playing with two alsatian puppies owned by Family Z, saying that she learnt about this from Mrs. Z. This accorded with the evidence that Mrs. X gave to the Commission. Mrs. Z told the Commission that her family

did not have alsatians and that no such conversations had taken place with Mrs. X and that Z.Z. was afraid of tractors and dogs. It appears to the Commission that, irrespective of any question concerning the accuracy or otherwise of the account of Z.Z.'s being on a tractor and playing with dogs, Mrs. X must have been the source of that information recorded in Mr. Conaty's report.

7.137 There was nothing in Mr. Conaty's typewritten report to indicate that he had mentioned Mrs. X's explanations for Z.Z.'s bruising and poor presentation to Family Z when he met with them on 11th February, 1993 (see below). Had he done so, he would have been in a position to consider any response given by Mrs. Z.

7.138 Mr. Conaty's report of the meeting also recorded that Mr. and Mrs. X told him that Mrs. Z had telephoned them on 4th February, 1993 for a "*social chat and naturally [Family X] inquired about [Z.Z.] and there were no complaints*", that Mrs. Z had also said that if she was going away for any period of time she would possibly ask Mr. and Mrs. X to take Z.Z. and, finally, that Mrs. Z had also recommended them to another family who needed respite care for a child. Mrs. Z told the Commission that she doubted very much if she had spoken to Mrs. X on the telephone to that effect. She did not recall any conversation about Family X's taking Z.Z. if she was going away and said "*I doubt very much if [that conversation] did take place*". She also said that she did not recommend Family X to anyone else at any stage.

7.139 The Commission is satisfied that Mr. Conaty, accompanied by Ms Greaney, visited Mr. and Mrs. X at their home on 8th February, 1993, as recorded in his report.

7.140 The visit which Mr. Conaty and Ms Greaney paid to Mr. and Mrs. X was prompted by the concerns which had been raised in the Unit's report. The Commission is satisfied that Mr. Conaty discussed its contents with Mr. and Mrs. X and obtained comments from them on certain matters outlined in it. Given the level of detail recorded in Mr. Conaty's report of his discussion with Mr. and Mrs. X about the content of the Unit's report the Commission is satisfied that Mrs. X could not be correct in recalling that the meeting lasted only ten minutes.

7.141 Insofar as the accuracy of Mr. Conaty's record of his discussions with Mr. and Mrs. X on the Unit's report is concerned, it is evident that much of the information recorded in it could only have come from Mr. and Mrs. X.

7.142 The Commission is satisfied that Mr. Conaty's report of his discussions with Mr. and Mrs. X reflects that they were given an opportunity to comment on the content of the Unit's report and the concerns about their care of Z.Z. during her time with them.

Correspondence between Mr. Conaty and Sr. Sigma on the notebooks

7.143 Following on from Mr. Conaty's meeting with Mr. and Mrs. X, he wrote to Sr. Sigma on 11th February, 1993, asking if she could make the notebooks available to him for the period between 28th November, 1991 and 3rd December, 1992. She replied on 15th February, 1993, stating that the Unit did not retain the notebooks as anything of daily significance pertaining to each child was entered daily into the Unit's report book and from there into the relevant child's file. His report recorded that Mr. and Mrs. X were "*extremely unhappy*" about that and, moreover, would continue to be unhappy until the Unit could give a "*satisfactory answer*", an area which Mr. and Mrs. X indicated they intended pursuing.

Mr. Conaty's meeting with Family Z - 11th February, 1993

7.144 Due to Mr. Conaty's death the Commission was unable to take his evidence on his account of this meeting.

7.145 Mr. Conaty's report to Dr. O'Boyle set out that he telephoned Family Z on 8th February, 1993 and spoke to both Mr. and Mrs. Z. He recorded that during their telephone conversation, Mr. Z told him that Family X were very good to Z.Z. and that Mrs. Z was "*extremely upset about the whole thing*". His report set out that Mrs. Z wanted to know who mentioned her name and Mr. Conaty told her that it came to the health board's attention from Ms Doyle and the Waterford Day Unit. Mrs. Z told him that Mrs. X had been in touch with her. Mr. Conaty recorded that he told Mrs. Z that he would rather not discuss the situation over the telephone and they arranged to meet on 11th February, 1993 in Family Z's house.

- 7.146 According to Mr. Conaty's note of the meeting in question, it was attended by himself, Ms Greaney, Mr. and Mrs. Z, and a friend of Mr. Z's who was a legal executive working in a solicitor's practice.
- 7.147 Mrs. Z told the Commission that the legal executive was first to arrive at Family Z's house. She explained his presence by reference to their feeling "*very vulnerable really*" because, she said, nobody was believing her and that they "*needed [their] own advice*". She pointed out that an official was coming to her house and that "*I had to protect myself*". The legal executive said that Family Z wanted him there as "*some degree of security*".
- 7.148 Mrs. Z's evidence of what she had told the legal executive about the situation varied somewhat. She said that "*I told him the story as I had told everybody else about [Z.Z.] [about the alleged incident in December, 1992].*" However, she said that she did not tell him anything about all the things that the Waterford Day Unit had told her and that "*[w]e wouldn't have gone into detail because he had just arrived really before [Mr.] Conaty arrived*". It was not entirely clear from her evidence if she had given the legal executive any account of an incident at home and her concerns over it. She explained that, "*...probably I might have said to him that we had problems in the foster home and that she was abused, that would be as much as I would have said probably.*" However, asked if her memory was that she told the legal executive about an incident in her house she said that she "*...would say so. Yes*".
- 7.149 The legal executive's evidence differed. He said that when he arrived at Family Z's house, he was told that Family Z were aware that there was a person calling from the health board. Family Z did not know who that person was or why that person was calling. They were concerned about their daughter, Z.Z., and suspected that she was not being treated properly in a home where she was staying. The legal executive was not aware where that home was. The legal executive's evidence to the Commission was that he was not told by Family Z what their particular concerns were or of any complaint to the health board that might have prompted the visit. The legal executive told the Commission that if there had been any mention of any sexual impropriety or interference with Z.Z., it would have stuck in his mind.

- 7.150 The Commission is satisfied that the legal executive was given a non-specific account of concerns about Z.Z. in a placement when he arrived at Family Z's house before the meeting.
- 7.151 Mrs. Z recalled that Mr. Conaty then came to the house after the legal executive. She did not recall Ms Greaney's being with him. Mr. Z had no real recollection of the meeting and could not recall who was at it apart from the legal executive. Neither he nor the legal executive could recall Ms Greaney's being present.
- 7.152 It appears that the meeting was somewhat fraught. Mr. Conaty described it in his report as *"tense"*, Mrs. Z in evidence described it as *"very tense"*, and the legal executive said in evidence that it was *"heated"* and *"unpleasant"*, leading him to conclude that it should be cut short. Mrs. Z recalled that Mr. Conaty stood behind the couch in the sitting room and never sat down. She told the Commission that *"nobody sat down, that will tell you how comfortable we were."* The legal executive also recalled that they were all standing.
- 7.153 Mrs. Z said that there was very little conversation with Mr. Conaty and that there was no conversation about the concerns the Waterford Day Unit had raised or Z.Z.'s position at all.
- 7.154 Mrs. Z said that she did not tell Mr. Conaty about the alleged incident at home in December, 1992 nor did he ask her about it. She told the Commission that *"it wasn't that kind of a meeting to be honest"*.
- 7.155 She said that Mr. Conaty then gave her a questionnaire to complete with about 50 questions on two foolscap pages requiring, in each case, a "yes" or "no" answer.
- 7.156 Mrs. Z was unable to remember the questions except for one, saying *"the only one I remember was a question, it was being put that the abuse had happened in our home and that it would maybe be my husband or my son"*. She considered that *"they were pushing the blame on us as a family"*. Mr. Z recalled that he was of the opinion in evidence that he and his son were *"suspects"*.

- 7.157 Mrs. Z said that the legal executive advised her to answer the questions in the negative. She said that she returned the questionnaire to Mr. Conaty who then left. She thought she signed it beforehand, although she was not certain this was the case.
- 7.158 The legal executive recalled reading a document at the meeting but he could not remember who gave it to him or what its contents were.
- 7.159 There was no mention of a questionnaire in Mr. Conaty's report. The Commission has no sight of any document that could be so described in the disclosure made to it during its investigations.
- 7.160 Before leaving, Mr. Conaty asked Mrs. Z whether she had any complaints about Mr. and Mrs. X. She told him that she had none, saying in evidence "*I had none because [the legal executive] had said to me, look, just say no ... and say that you have no more to say*". The legal executive had no recollection of this request from Mr. Conaty as having occurred.
- 7.161 On the issue as to whether Mrs. Z had told Mr. Conaty that she had no complaint against Family X, she explained:

"I was fearful about maybe getting in trouble with [Family X] and with the health board. If I wanted to press charges of that, of abuse, I could have ended up in court and I didn't have the funds to take on the HSE or to take on anybody at that stage to be honest with you and the best thing to do was box it and let it go".

- 7.162 In his evidence on the meeting, the legal executive said that Family Z were fearful that they could make matters worse for Z.Z. by making a complaint about their concerns.
- 7.163 Mrs. Z's own view of the meeting was of Mr. Conaty's having her "*snookered*", a view she took based on a potential liability to Mrs. X and the health board if she answered some of the questions in the affirmative. She inferred from his questioning that he did not want them to go forward with their complaint, saying that, in her view, he was "*throwing the ball back into the family*".

- 7.164 The Commission is satisfied that Mr. Conaty had some document with him at the meeting which he used during his conversation with Family Z. The Commission cannot be satisfied, however, that this is properly described as a questionnaire or that Mrs. Z signed any document. The Commission is satisfied that such questions as were raised of concerns about Z.Z., whether by reference to a document or otherwise, were answered with a “no” by Mrs. Z.
- 7.165 Mr. Conaty’s report to Dr. O’Boyle contained details of his discussions with Family Z at this meeting. Mrs. Z took issue with passages of it during her evidence, before finally expressing the view that his record of their conversation was “*all made up*”.
- 7.166 For instance, Mr. Conaty had recorded Mrs. Z as saying that she only passed the Waterford Day Unit’s concerns on to Ms Doyle and removed Z.Z. from Mr. and Mrs. X because of the advice given to her by the Unit. He recorded that she did not accept the gravity of the concerns and had returned Z.Z. to them because of the esteem and respect which both she and her husband had for Mr. and Mrs. X, coupled with the fact that they were aware that they were “*genuinely loving and caring*” to Z.Z. Mrs. Z said that they “*didn’t have that type of a conversation. It was a very tense, it was a very short meeting. There was nothing discussed like that*”.
- 7.167 Mr. Conaty’s report also recorded the fact that he raised the “*bite-like*” mark to Z.Z., recorded in the Unit’s report, his report noting that Mr. Z was “*anxious*” about that, “*since the bite mark was noted ... the school did not inform either him or his wife given that they had a note of it on the 7th*”. Mrs. Z said that she could not remember this anxiety. According to Mr. Conaty’s report, Mrs. Z explained that Z.Z. had a habit of biting her hand when in a temper. Mrs. Z said that there was “*no conversation like that*”. She said in evidence, however, that it was a “*kind of mannerism that [Z.Z.] would have*”.
- 7.168 Mr. Conaty’s report stated that Mr. and Mrs. Z pointed out that they considered Z.Z. to be “*extremely happy with [Family X]*” and that they “*regretted the entire situation*”. They were satisfied that Z.Z. got “*proper care and attention and love from [Family X]*” and told him that they did not feel that any of the conduct justified ending the arrangement with Mr. and Mrs. X. He noted that “*Mrs. [Z] respected and did not wish to hurt [Family X] by making any complaints*”.

especially since she had no reason to be as a mother and the legal guardian of her daughter unduly concerned". Mrs. Z told the Commission she did not say those things. The legal executive could not recall Mrs. Z's saying any of this.

7.169 Mr. Conaty's report also recorded that Family Z were "*naturally anxious*" to know what the situation was at that point. He set out that he and Ms Greaney advised Family Z that they would clarify the situation with Mr. and Mrs. X, who might be of the view that Mrs. Z had been making the allegations. Again, Mrs. Z said that she could not remember having a discussion of that sort.

7.170 Asked about her contact with Mr. and Mrs. X after the meeting with Mr. Conaty, Mrs. Z said that she never collected Z.Z.'s clothes or her cot from them as she wanted to avoid confrontation. She said "*...I must have just rang Mrs. [X] and informed her that we had no finances [and] we could not afford to let [Z.Z. stay] down there any more*". She thought that the last time she was at Family X's house was during the few days that Z.Z. went back there, from 8th to 11th January, 1993. Mrs. Z told the Commission that she thought that she might have made the excuse about her financial situation at that point, but could not be sure.

The meeting at Family Z's – conclusions

7.171 The meeting between Mr. Conaty and Family Z was prompted by concerns that had been raised by the Waterford Day Unit and Ms Doyle about Z.Z.'s care by Family X, all of which Mrs. Z was aware of from her conversations in early January, 1993 with Ms Doyle.

7.172 Mrs. Z, in her conversations with Ms Doyle in January, 1993, had been concerned that Z.Z.'s particular case not be discussed at the meeting to be held between health board officials and Ms Doyle on 15th January, 1993 and had not wanted to raise the concerns with respect to Z.Z. with Mrs. X when discontinuing Z.Z.'s placement with her in December, 1992 and then finally in January, 1993. When contacted by Mr. Conaty on 8th February, 1993 to arrange a meeting, Mrs. Z was concerned to know who had mentioned her name to him. Mr. Conaty preferred not to discuss the matter over the telephone and, as indicated above, arranged to meet Family Z at their home. He had never met them before that.

- 7.173 It is clear from the evidence gathered by the Commission that the meeting was tense. Contributory factors were the stress and pressure that Mrs. Z was under in sourcing a new placement for Z.Z. and in coping with significant domestic pressures at this time. The meeting itself was undoubtedly an additional stressor for Family Z to contend with.
- 7.174 The Commission is satisfied that Mr. and Mrs. Z were very apprehensive before Mr. Conaty's visit. Mrs. Z gave evidence that they arranged that the legal executive be present because an official was coming to her house and she had to protect herself. She felt vulnerable. Mrs. Z said that this was because nobody was believing her and that they needed their own advice.
- 7.175 In coming to the meeting, Mr. Conaty was aware from Ms Doyle's report to Dr. O'Boyle of 14th January, 1993 of the pressures on Mrs. Z and Family Z. He also had read the Unit's report setting out observations with respect to Z.Z. in the context of her placement with Family X over a sustained period of time. Notwithstanding this, there was no evidence that he took into account the stresses and concerns of Family Z or took any steps in his role as Senior Social Worker to put them at their ease or to communicate what were the concerns and priorities of the health board in carrying out the investigation. In this regard, the Commission considers that an investigation into allegations from any source regarding the treatment and welfare of a child is inevitably going to be a stressful matter for that child's parents.
- 7.176 As discussed above, Mr. Conaty had a somewhat sceptical attitude to the concerns raised in respect of Z.Z. The combination of this and Family Z's sense of significant apprehension preceding the meeting was particularly unfortunate.
- 7.177 The Commission is satisfied that Mrs. Z conveyed to Mr. Conaty that she had "*no complaint*" against Family X, but cannot be satisfied on the evidence taken by it that this was expressed in the fulsome and extensive manner in which it was set out in his report or that it extended to such a complete endorsement of Mr. and Mrs. X.
- 7.178 The Commission's view is that this must be understood in the context of the manner in which the meeting took place, including Mrs. Z's belief that blame was being placed on her family for anything that may have happened to Z.Z.

and her fear that pressing a complaint about abuse could have resulted in her becoming embroiled in a dispute with Mr. and Mrs. X and the health board and ending up in court. The family's financial situation around this time was precarious.

7.179 Despite the fact that no complaint was made to Mr. Conaty by Family Z concerning Z.Z.'s care by Mr. and Mrs. X, it remains the case that, as pointed out above, he had read the Unit's report which had set out detailed observations concerning Z.Z. over a lengthy period of her placement with Family X. He also had Ms Doyle's report to Dr. O'Boyle containing information about her engagement with the Unit staff who had brought concerns about Z.Z.'s placement with Family X to her attention and about her subsequent dealings with Mrs. Z.

7.180 A matter of critical importance in receiving notification of these concerns was that Z.Z. was a young child who had significant disabilities and communication difficulties.

7.181 The Commission considers that all of these aspects obviously called for a probing investigation by Mr. Conaty, as opposed to one which culminated, in effect, in matters being concluded on the basis of the general sort of reassurances which appeared to satisfy him during this relatively short meeting at Family Z's home.

7.182 It is clear from the evidence that Mr. Conaty did not demonstrate an appetite for investigation but rather an overreadiness to accept reassurances that accorded with a somewhat sceptical approach to investigations of this nature from the outset.

7.183 Mr. Conaty did not put any of the information provided to him by Mrs. X to Family Z so as to check whether or not there was agreement between them on matters that might have assisted him in considering whether there were outstanding issues of concern that required further investigation.

7.184 Mr. Conaty did not ask to see or meet Z.Z. and so was unable to make even the most preliminary assessment as to how she appeared in the light of the matters highlighted in the report from the Waterford Day Unit.

Mr. Conaty's meeting with Family X - 22nd February, 1993

- 7.185 Following his visit to Family Z, Mr. Conaty returned to Mr. and Mrs. X on 22nd February, 1993. According to his report to Dr. O'Boyle, he told them that Family Z were "*extremely upset*." He set out that "*Mrs. [X] has been in touch with [Family Z] on various occasions and despite acrimony [Family X] genuinely care for [Z.Z.] and [Family Z] accept this*".
- 7.186 Mrs. X had no recollection of this meeting at all with Mr. Conaty and did not recall that her husband had participated in a meeting with him.
- 7.187 Mr. Conaty's report continued by stating that "[a]s *promised to [Family Z], I outlined to [Family X] that [Family Z] only acted on the advice of the [Waterford] Day Unit*". His report recorded that Mr. X was "*anxious that it should be noted that the child travelled by bus and it must be respected that whilst these are 'grey areas' they should be noted*". Mr. Conaty set out that Family X was "*disappointed*" that the Waterford Day Unit notebook was not available.
- 7.188 His report ended by stating that the "*present situation*" was that Mr. and Mrs. X cared for Grace, who was then aged 14, full-time, and for another person on alternate weekends from Residential Facility B. He considered that that was sufficient, having regard to Mr. and Mrs. X's ages, and that if any request was made of Mr. and Mrs. X to provide care for anyone else, the health board should be notified. He expressed the view that "*given the bond*" between Z.Z. and Family X, it should not be broken "*in light of enquiry and until such time as alternative arrangements be made by [Family Z] the situation should continue*".

Conclusion of investigation

- 7.189 The conclusion of Mr. Conaty's investigation was to the effect that the concerns raised with respect to Z.Z.'s placement with Family X were entirely unfounded.
- 7.190 Mr. Conaty's investigation concluded with two letters on 23rd February, 1993. The first was to Ms Doyle. The second was to Dr. O'Boyle and enclosed Mr. Conaty's report on the outcome of his investigation.
- 7.191 In his letter to Ms Doyle, Mr. Conaty set out the following:

“Dear Ms Doyle,

I refer to yours of the 2/12/1992 with copies addressed to Dr. Betty Walsh, Senior Area Medical Officer, S.E.H.B., Nurse Kathleen O’Sullivan Advisory Nurse for Mentally Handicapped, S.E.H.B., Ms Kitty Greaney Children[’s] Officer, St. Joseph’s Hospital, Dungarvan and [name] Social Worker, St. Patrick’s Kells Rd., Kilkenny. This is to confirm that following investigations there is no evidence to the best of our knowledge that there has been any neglect to any children in the care of Mr. & Mrs [X].

Since you refer specifically (15/1/93) to [Z.Z.], it appears no corroborative evidence has been found to substantiate this.

[Family Z] wish their child to remain in the care of Mr. & Mrs. [X] and we can see no objection to this.

Yours faithfully

Pat Conaty,

Senior Social Worker

C.C. All listed above

Dr.O’Boyle, A/DCC & MOH., Community Care

7.192 A handwritten annotation on Mr. Conaty’s letter indicated that it was to be copied to Mr. and Mrs. X.

7.193 Ms Doyle confirmed that receipt of that letter ended the matter as far as she was concerned.

7.194 In Mr. Conaty’s letter to Dr. O’Boyle, entitled as being in relation to “[Waterford] Day Care Unit and [Z.Z. of a specified address]”, he set out the following:

“Dear Dr. O’Boyle,

Further to our conversations of concern regarding the above matter I am enclosing detailed report following letter of 2/12/1992 from Ms. Martina Doyle expressing concern, in general, regarding [Family X] and in particular regarding [a child named Z.Z.], together with my responses. I trust you will find that the investigation was carried out in a satisfactory and professional manner and I have no hesitation whatever in using the yard stick should I wish to place my child in the care of [Family X], I would have no hesitation in doing so.

I would equally point out that in the course of our investigations [Family Z] had nothing but the utmost praise for the care and attention [Family X] gave their daughter.

Yours sincerely,

P.Conaty,

Senior Social Worker”.

- 7.195 In his evidence to the Commission, Dr. O’Boyle could not remember receiving that letter, nor any conversations with Mr. Conaty about his investigation.
- 7.196 Mrs. Z told the Commission that copies of those letters were sent to her by, she thought, Ms Doyle in 1993 or 1994. Mrs. Z said that pinned to the two letters was a tiny slip of paper with “*keep these safe, MD*” written on it. She said, “*I took it for granted that it was [Ms Doyle].*” Ms Doyle told the Commission that she did not give Mrs. Z the letters, referring to the fact that the letter from Mr. Conaty to Dr. O’Boyle was internal health board correspondence to which she would not have been privy until she received it from the Commission. Dr. O’Boyle also said that it was most unlikely that he would have sent Mrs. Z the letter that he received from Mr. Conaty. The Commission did not have the benefit of Mr. Conaty’s evidence on this matter. In the circumstances the Commission is unable to establish who sent the two letters to Mrs. Z.

8. Findings - Mr. Conaty's investigation with respect to Z.Z.

8.1 The Commission considers that the conduct of Mr. Conaty's investigation into the concerns raised with respect to Z.Z. was flawed and inadequate and failed to have adequate regard to the concerns raised by the Waterford Day Unit and Ms Doyle with the health board. In particular the Commission is satisfied that this was so in a number of key aspects:

- (a) Mr. Conaty was the health board official charged with conducting the investigation into allegations communicated to the health board referred above. In this he was assisted and supported by Ms Greaney, the board's Children's Officer who accompanied him to the relevant meetings. The Commission is satisfied that the conduct of the investigation and its outcome were Mr. Conaty's responsibility;
- (b) it is clear from the totality of the evidence that Mr. Conaty took an inappropriate approach to the concerns notified to the health board from the outset. He approached the concerns reported with scepticism from the start. In this regard, the Commission is satisfied that Mr. Conaty's view as to the percentage of allegations that were generally without substance, unfortunately carried with it a strong element of pre-judgement which the Commission is satisfied undermined from the outset his capacity to conduct an impartial, independent and robust investigation into the concerns notified to the health board;
- (c) in carrying out his initial steps in the investigation and before engaging with anyone with regard to the nature of the concerns, the Commission is satisfied that Mr. Conaty placed disproportionate weight on what he considered to be the belated nature of the communication of concerns to the health board and adopted an overly sceptical attitude to the fact that Mrs. Z had allowed Z.Z. to remain in her placement with Family X. In this regard, the Commission is satisfied that, as an officer of the health board investigating concerns such as those reported, he failed to have regard to the evident pressures on Mrs. Z to maintain a placement for Z.Z. at this time, which had been reported to him by Ms Doyle;

- (d) Mr. Conaty also placed disproportionate weight on the question of why Mrs. Z did not disclose to Mrs. X her reason for removing Z.Z. from her;
- (e) given that the concerns reported to the health board were concerns noted by the Waterford Day Unit over a period of time with respect to the presentation of an intellectually disabled child, the Commission is satisfied that an open rather than an overly sceptical approach to the concerns reported should have underpinned Mr. Conaty's investigative approach;
- (f) the Commission considers it to have been an unusual step in an investigation for Mr. Conaty to have visited Mr. and Mrs. X to interview them about the concerns communicated to the health board regarding Z.Z. before he had spoken to Mr. and Mrs. Z. The Commission does not have Mr. Conaty's evidence on the sequencing of his visits. It is the case, however, that while he had not yet visited Family Z he had significant information from the Waterford Day Unit's report to raise with Mr. and Mrs. X at that stage. Having decided to visit Mr. and Mrs. X first, however, there is no indication that the responses and information provided to him by Mr. and Mrs. X were appropriately considered in the context of an investigation into concerns about Z.Z. In particular, there were various responses and explanations furnished by Mr. and Mrs. X. At the very least, these needed to be checked with Family Z before Mr. Conaty could have even identified the areas of potential dispute between Family Z and Mr. and Mrs. X on matters concerning Z.Z.'s presentation;
- (g) the Commission's findings on the meeting at Family Z's are at paragraphs 7.171 to 7.184 above. The Commission is satisfied that this meeting was not properly conducted by Mr. Conaty;
- (h) the Commission is also satisfied that regardless of how the meeting at Family Z's proceeded, it was a failure on Mr. Conaty's part to regard his investigation into the concerns raised about Z.Z. by the Unit and Ms Doyle as complete or at an end by virtue of the fact that Family Z had told him that they did not have any complaints about Z.Z. while in the care of Family X; and

- (i) the outcome of Mr. Conaty's meeting with Family Z notwithstanding, Mr. Conaty had notification of serious concerns with respect to Z.Z. as set out in the Unit's report and that from Ms Doyle to Dr. O'Boyle, all of which required careful investigation. Such investigation, however, never took place.

8.2 At what Mr. Conaty considered to be the completion of his investigation, he notified Dr. O'Boyle of his conclusion that the reported concerns had proved unfounded. The Commission is satisfied, however, that the report provided to Dr. O'Boyle was, in the light of the Commission's examination of the evidence, fundamentally flawed. In particular:

- (a) aspects of the matters reported during the meeting of 15th January, 1993 at the outset of his investigation were not included in his report. In particular there was no reference to Ms Doyle's informing the meeting that Z.Z. had been seen by a paediatrician in Cork in 1991 for "*?vaginal infection + sexualised behaviour, result allegedly NAD [nothing abnormal detected].*" There was also no reference to the concern which Ms Doyle raised that Mr. and Mrs. X took children and adults privately without notifying anyone, which, in his notes of the meeting, Mr. Conaty had recorded "*would not be in keeping with the Boarding Out Regulations as implemented by the [health board]*";
- (b) a conclusion was communicated in Mr. Conaty's report of the meeting of 15th January, 1993 at which the report of the Waterford Day Unit was to hand, that "*[h]aving listened to the entire situation surrounding the concerns it appeared on the face of it that the concerns raised posed the question of quality of care as opposed to any form of neglect...*" In this regard, as set out above, Mr. Conaty told the Commission that looking at the report from the Waterford Day Unit at this stage, Z.Z.'s welfare was "*sticking out a mile*"; and
- (c) Mr. Conaty provided reassurances in his report which were entirely unqualified. He failed to engage in any way with what ought to have been at the core of his investigation into concerns with respect to Z.Z., namely what lay behind the significant issues of concern that had been reported to the health board with respect to a vulnerable child, in

particular by her day care centre which had observed her over an extended period of time.

- 8.3 The Commission is satisfied that in line with the unqualified nature of Mr. Conaty's report to Dr. O'Boyle, consideration of the necessity for a case conference to be called within the health board arising from the reported concerns simply did not arise having regard to his conclusions as reported to Dr. O'Boyle.
- 8.4 Mr. Conaty's failure to write formally to Family Z and notify them of the outcome of his investigation is also difficult to understand. The Commission did not have Mr. Conaty's evidence on this aspect. Insofar as Mr. and Mrs. Z may have received copies of the letters under cover of a slip of paper, not identifying the sender, the Commission is satisfied that this was not adequate performance of the health board's duty to notify them of the outcome of an investigation into concerns about the care of their daughter.
- 8.5 While the Commission has concluded that the investigation conducted by the health board into the concerns raised with respect to Z.Z., when in the care of Mr. and Mrs. X, was fundamentally flawed, it can make no finding in Phase One of the investigation with respect to the allegations concerning persons other than Grace. Pursuant to Part X of its Terms of Reference, the Commission is to consider the question of further investigations, if any, which may be undertaken having regard to the facts established and information in its possession.⁷

9. Findings - Mr. Conaty's investigation with respect to Grace

- 9.1 The Commission is satisfied that there was a failure of duty on the part of the health board properly to monitor and review Grace's foster care placement having regard to the nature and conduct of the investigation into concerns reported to the board in December, 1992 and January, 1993. In particular:

- (a) there is no evidence of any investigation by the health board of the concern communicated to the board by Ms Doyle that Mr. and Mrs. X

⁷ See also paragraph 1.6 above.

were taking private placements or of her concern that the board was not aware of this;

- (b) this concern was clearly relevant to Grace's position as a child with high care needs who had been placed in foster care with Mrs. X. No consideration was given as to whether there was a potential impact on Grace's care by the taking on of other private placements in the house while also caring for Grace;
- (c) Mr. Conaty's investigation into the concerns reported about Z.Z. while in the care of Mr. and Mrs. X, failed to have any regard at any stage whatsoever to the position of Grace within that family;
- (d) the Commission is satisfied that this was a significant and fundamental failing in the health board's duty to monitor and review Grace's position as a foster child. This failing was all the more profound having regard to the fact of Grace's overall vulnerability in the light of her particular disabilities;
- (e) Mr. Conaty's evidence that he had not attached any importance to the presence of Grace in the Family X household and did not view his investigation from her perspective is illustrated by the failure even to observe Grace in the course of his investigation;
- (f) in circumstances where Mr. Conaty had not in fact carried out any investigation with respect to the care of any other child by Mr. and Mrs. X at this time, and in particular with respect to Grace, the statement in his report to Dr. O'Boyle that there was *"no evidence to the best of our knowledge that there has been any neglect to any children in the care of Mr. and Mrs. [X]"* was not sufficiently grounded. While it is important to emphasise that this is not to be taken as suggesting that there was such evidence, the Commission is satisfied that an assertion of this kind was entirely inappropriate where Grace had simply been invisible to Mr. Conaty and her position as a foster child in the house disregarded; and
- (g) given Mr. Conaty's acceptance at the Commission of the welfare issues identified with respect to Z.Z. in the Unit's report, the Commission

considers that, at the very minimum, a review of Grace's welfare in the placement should have been initiated once concerns with respect to Z.Z. were communicated to the health board.

10. Findings - Dr. O'Boyle's role in the investigations

- 10.1 As Director of Community care, Dr. O'Boyle had overall responsibility for monitoring and coordinating cases of suspected child abuse occurring in his area. However the Commission is satisfied that Dr. O'Boyle's knowledge and familiarity with the Guidelines, which applied to investigations of such allegations in the SEHB area, was scant. Dr. O'Boyle had some knowledge of his duties and obligations under the Guidelines and this was derived from his practice and the general exercise of his professional judgement rather than from a knowledge of what the Guidelines actually contained.
- 10.2 The Commission considers on the facts that it was of considerable importance for Dr. O'Boyle to be sufficiently familiar with the Guidelines in order fully to understand his role and properly carry out his functions when concerns about possible abuse of a child were brought to his attention.
- 10.3 It is important, however, to note the emphasis in the Guidelines that in carrying out functions under the Guidelines, the Director was "*heavily dependent*" on the senior members of his team.
- 10.4 The Commission is satisfied that Mr. Conaty, as Senior Social Worker, was the appropriate person to gather information with regard to any allegation of abuse received in the health board's Community Care Area, to conduct the investigation, and to report to the Director of Community Care. This was part of his role.
- 10.5 It was in the context of Mr. Conaty's investigatory role that Dr. Walsh sent him the report of the Waterford Day Unit on 13th January, 1993. Mr. Conaty was also furnished with a copy of Ms Doyle's letter to Dr. O'Boyle of 14th January, 1993 and was also aware of Ms Doyle's concerns about Family X, as communicated to him by her letter of 2nd December, 1992. Mr. Conaty possessed all the key information about the concerns pertaining to Z.Z. as it existed at that time.

- 10.6 Dr. O'Boyle, by contrast, was not copied into the correspondence between Mr. Conaty and Ms Doyle of 2nd December 1992, and between Ms Doyle and Dr. Walsh of 22nd December, 1992, respectively. He did not recall seeing the Waterford Day Unit's report until he received it from the Commission.
- 10.7 Dr. O'Boyle was informed by Ms Doyle in her report of 14th January, 1993 of certain key concerns about Z.Z. and the difficulties Family Z were facing in relation to her care. At that stage, a meeting had already been arranged between Ms Doyle and health board officials for the following day and the investigation by Mr. Conaty was already underway.
- 10.8 With regard to the gathering of information and the investigation of allegations of abuse, the Commission is satisfied that Dr. O'Boyle was guided by the Senior Social Worker and relied upon what he considered to be Mr. Conaty's expertise in that position. The Commission considers that it was reasonable for Dr. O'Boyle to have taken this view.
- 10.9 A key role for Dr. O'Boyle under the Guidelines was the responsibility for convening case conferences, where this was considered necessary. Dr. O'Boyle was unaware of this responsibility. He said, however, that in practice he arranged case conferences when requested to do so by a senior member of his team or by an outside body, such as the Brothers of Charity.
- 10.10 The Commission is satisfied that it was the function of the Senior Social Worker, in reporting on the information gathered by him in the course of his investigation, to advise the Director as to whether a case conference was considered necessary in the circumstances. No such recommendation was made in Mr. Conaty's report to Dr. O'Boyle, having regard to Mr. Conaty's findings.
- 10.11 In light of the report received by Dr. O'Boyle and the findings of Mr. Conaty's investigation as conveyed to him, the Commission is satisfied that the making of arrangements to convene a case conference was simply not a matter that arose for Dr. O'Boyle's consideration.
- 10.12 Notwithstanding Dr. O'Boyle's responsibilities under the Guidelines and his lack of familiarity with the responsibilities these imposed on him, the

Commission is satisfied that the inadequacies and failings that arose in the conduct of the investigation were primarily those of Mr. Conaty.

11. Findings – SEHB’s role in the investigations

- 11.1 The failure to treat and properly investigate the allegations communicated to the South Eastern Health Board with respect to Mr. and Mrs. X and concerning Z.Z. was a failure of that board. The Commission is satisfied that the apparent lack of provision by the SEHB of training and instruction for personnel in the Community Care Area charged with the carrying out of such investigations, to ensure adequate expertise in their proper conduct, contributed significantly to these failings.
- 11.2 Insofar as Mr. and Mrs. Z received copies of letters under cover of a slip of paper, not identifying the sender, the Commission is satisfied that this was not an adequate performance of the health board’s duty to notify them of the outcome of an investigation into concerns about the care of their daughter.
- 11.3 The Commission is satisfied, having regard to all of the above, that the South Eastern Health Board failed properly to investigate the allegations made in respect of Z.Z.’s placement with Mr. and Mrs. X.
- 11.4 Consideration of the position of Grace ought to have arisen in the context of the investigation of the complaint in respect of Family Z. The South Eastern Health Board failed to give such proper consideration to the position of Grace in her placement with Mr. and Mrs. X as part of that investigation.

12. HSE’s apologies to Mrs. Z and Z.Z.

Apology of Ms Colley

- 12.1 On 9th December, 2015, Aileen Colley, Chief Officer in the HSE, wrote to Mrs. Z. She referred to the Devine investigation into Grace’s placement with Family X and the review by Resilience Ireland of all clients who had contact with them in which, she noted, Mrs. Z had chosen not to take part. She stated that the HSE was releasing that same day a number of extracts from the Devine report, namely the terms of reference, methodology and a number of observations and

recommendations, and went on to say that the HSE *“apologises for any failings identified and to those who received poor care when placed with this foster family”*.

Apology of Mr. O’Brien

12.2 On 1st February, 2016, Mr. Tony O’Brien, Director General of the HSE, wrote to Mrs. Z, referring *inter alia* to Ms Colley’s letter which, he said, *“contained an official apology to you and [Z.Z.] on behalf of the HSE”*. He adverted to recent media coverage in relation to what he termed a *“mishandled attempt”* by the HSE to offer an official apology to a former resident (Grace) which he said no doubt raised *“many unpleasant memories for you and [Z.Z.]”* and about which he said he was *“unhappy”*, before going on to say *“I apologise to you for any of the subsequent media coverage that may have caused you or [Z.Z.] any distress”*.

12.3 He also said that it was *“clear from both of the unpublished reports that there were significant failings in the care provided by [Family X] and significant failures by the former Health Board (and subsequently the HSE) to make the situation safe”*. He said that: *“For this, I want to offer you and [Z.Z.] a full, sincere and heartfelt apology for the significant failings in care identified in both reports and for any subsequent effects these failings might have caused or may be causing you”*.

Commission’s questionnaires to HSE

12.4 Arising out of the above, by letter of 26th January, 2018, the Commission sent the solicitors for the HSE questionnaires which sought to ascertain a number of matters, chiefly the specific significant failures by the former health board (and subsequently the HSE) to make the situation safe; the persons responsible for those failings; the factual basis for the conclusion that Z.Z. was given poor care when placed with Family X; and whether the apology referred to the health board’s investigation in late 1992 / early 1993 into the care of Z.Z. by the Family X.

HSE's response

- 12.5 By letter dated 22nd February, 2018, the solicitors representing the HSE submitted completed questionnaires which had been answered on behalf of Mr. O'Brien and Ms Colley. The letter stated that *"[e]ach of the apologies arose following a review of the totality of each of the reports referenced in your correspondence. Neither of the authors referenced particular findings in either report to formulate the letters of apology, as will be evident from a cursory review thereof"*.
- 12.6 The content of the questionnaires was in similar terms, explaining that the letters of apology issued following a review of the totality of the Devine and Resilience Reports and that they did not seek to identify individual failings and should not be construed in that way. As regards the specific question of whether the apologies were referable to the health board's investigation in 1992/93, the response, in each case, was that the apology had issued following a review of the reports identified.

Response of Commission to completed questionnaires

- 12.7 The Commission replied to this correspondence in a letter of 26th February, 2018, explaining that the answers to the questionnaires were *"entirely unsatisfactory"* and *"of no assistance"* to it in carrying out its work, terming the answers as *"generalised"*, *"evasive"* and lacking clarity on the matters raised. Enclosed with the letter were two directions to Mr. O'Brien and Ms Colley, made pursuant to s. 16 of the Commissions of Investigation Act 2004, requiring them to answer the questions raised and to provide precise information as to the underlying accepted findings of fact which underpinned the apology to Mrs. Z.

Response of HSE to Commission

- 12.8 The HSE's solicitors replied to the Commission's directions on 12th March, 2018, enclosing questionnaires completed by Mr. O'Brien and Ms Colley.
- 12.9 The answers provided by Mr. O'Brien and Ms Colley indicated that the apologies that issued to Mrs. Z were general in nature, based on a review of the Devine and Resilience Reports, and not on any specific failures attributable

to individuals, or any specific findings of poor care having been given to Z.Z. by Family X.

12.10 Thus, Mr. O'Brien stated that his letter of apology to Mrs. Z *"issued following a review of the totality of the Devine and Resilience Reports"*. He referred to the publication of extracts of those reports, including the recommendations of the Devine Report, and stated that *"[i]n light of the failings which were identified in that report the decision was made to offer the general apology framed in the manner in which it issued."* He said that the apology's intention was not to identify specific failures and that it accordingly did not do so. He referred to that answer when dealing with the question seeking the identities of those responsible for particular failings, and said that the letter of apology *"did not seek to identify or apologise for the specific actions of individuals"* but was *"written corporately on behalf of the HSE which was also the successor in title to the [South Eastern Health Board]"*. He said that the *"precise factual basis"* for the conclusion that Z.Z. was given *"poor care"* was the content of the reports commissioned by the HSE. He stated that the HSE *"did not make individual findings of poor care prior to issuing the letter of apology"*.

12.11 Ms Colley's response was in similar terms. With regard to the question of what *"particular failings"* were identified in the reports that were specifically identifiable to Family Z, she explained that, in circumstances where extracts from the Devine Report were being released, it was deemed appropriate to contact all the service users of Family X, or their families, providing an apology for the failings identified in the reports. She said that the sentence specific to offering an apology was that the HSE *"apologises for any failings identified and to those who received poor care when placed with this foster family"* and asserted that the failings mentioned *"refer to the overall findings from both the aforementioned reports and are noted in a general and not individualised manner"*. She explained that that wording was contained in letters which issued to 35 people or their families, including Mrs. Z. She said that the letter informing those persons of the release of extracts *"was not intended or issued to reflect any individual or particular failings"*. She went on to say that the letter *"did not identify persons responsible for particular failings as this was not the purpose of the letter and should not be construed in that context"*. She stated further that *"[t]he letter is specific to the release of extracts of the reports...providing an apology for any failings identified. It was not individualised and the letter did*

not seek to identify individuals for any particular failings specific to any individual/s relevant to the 35 people written to”.

- 12.12 Ms Colley explained that the “*precise factual basis*” for the conclusion that Z.Z. was given “*poor care*” was “*the general failings identified in the Devine and Resilience Reports*”. She said that [n]o *specific findings of poor care were identified by the HSE in relation to Ms [Z] in the issuing of this letter*”. The reference to “*poor care*” was she indicated, not specific to Z.Z. “*but a reference to the findings from the Devine and Resilience Reports*”.

Non-applicability of apologies to health board’s 1992/93 investigation

- 12.13 Both Mr. O’Brien and Ms Colley confirmed that the apologies did not refer to the health board’s 1992/93 investigation. Mr. O’Brien said that his letter followed the publication of extracts from the Devine and Resilience Reports which were based on a review of documentation held by the HSE, including documentation concerning prior investigations carried out by the health board / HSE; however, the apology was referable “*specifically to the failings identified in those reports*”. He stated that the letter of apology “*did not therefore reference particular failings referenced in a previous investigation*”. Ms Colley said that her letter of apology “*was referable to the content, conclusions and recommendations of the Devine and Resilience reports only*”.

Appendix

- Letter dated 23rd February, 1993, Mr. Patrick Conaty to Dr. O'Boyle
- Mr. Patrick Conaty's Social Work Contact Sheet (Social Work Report) concerning Z.Z.

Letter dated 23rd February, 1993, Mr. Patrick Conaty to Dr. O'Boyle

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PC/POK.

23.2.93

PRIVATE AND CONFIDENTIAL

Dr. Martin O'Boyle,
A/Director of Community Care &
Medical Officer of Health,
South Eastern Health Board,
32, The Mall,
WATERFORD

RE: [REDACTED] Day Care Unit and [REDACTED] Child, [REDACTED]

Dear Dr. O'Boyle,

Further to our conversations of concern regarding the above matter I am enclosing detailed report following letter of 2/12/1992 from Ms. Martina Doyle expressing concern, in general, regarding the [REDACTED] and in particular regarding a

[REDACTED] together with my responses. I trust you will find that the investigation was carried out in a satisfactory and professional manner and I have no hesitation whatever in using the yard stick should I wish to place my child in the care of the [REDACTED] I would have no hesitation in doing so.

I would equally point out that in the course of our investigations the [REDACTED] family had nothing but the utmost praise for the care and attention the [REDACTED] family gave their daughter.

Yours sincerely,

P. Conaty,
Senior Social Worker

Encl.

**Mr. Patrick Conaty's Social Work Contact Sheet (Social Work Report)
concerning Z.Z.**

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PAGE: 1

FAMILY: [REDACTED]
ADDRESS: [REDACTED] Waterford

ATK:

1/12/1992

Letter from Martina Doyle Social Worker expressing concern regarding [REDACTED] Co. Kilkenny with whom children are placed with asking for a meeting.

Copies of her letter were addressed to Dr. E. Walsh Senior Area Medical Officer, Nurse Kathleen O'Sullivan, Advisory Nurse for the Mentally Handicapped, Ms. Kitty Greaney, Children's Officer and [REDACTED] Social Worker.

A meeting was arranged for the 15/1/1993 and the following personnel attended:

Dr. Elizabeth Walsh, Senior Area Medical Officer, Pat Conaty, Senior Social Worker, Ms. Kitty Greaney, Children's Officer, Ms. Martina Doyle Senior Social Worker Brothers of Charity and Ms. Kathleen O'Sullivan Counsellor for Mentally Handicapped.

Ms. Doyle started the meeting by outlining her request for a meeting because she was generally concerned regarding children placed with the [REDACTED] as the result of concerns which had brought to her attention that she was to avail of the occasion to meet with the appropriate personnel.

She had consulted with the [REDACTED] Day Care Unit and [REDACTED] regarding concerns they had.

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FAMILY: [REDACTED]

ADDRESS: [REDACTED]

DATE:

A report was to hand which had been written by [REDACTED] Unit Director and [REDACTED] Registered Nurse for the Mentally Handicapped regarding [REDACTED] dated 12/1/1993.

It was noted that respite care was terminated & Ms. Doyle did point out that [REDACTED] returned her child for a short period over Christmas to the [REDACTED] family but did not express any concern direct to the family and according to Ms. Doyle, [REDACTED] did not want the matter to go any further.

The report from the [REDACTED] Day Unit spanned a period from Dec 1991-Christmas 1992 and outlined incidents of concern which were documented.

Ms. Doyle alleged [REDACTED] told the [REDACTED] she was removing the child for financial reasons which appeared to be an excuse and was in fact a lie to the [REDACTED]. The child continues to attend the [REDACTED] Day Unit and according to Ms. Doyle, [REDACTED] told her that she continued to leave the child in [REDACTED] because it was the only option she had.

Having listened to the entire situation surrounding the concerns it appeared on the face of it that the concerns raised posed the question of quality of care as opposed to any form of neglect but

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DATE: _____

in light of the fact that the report from the [REDACTED] Unit spans a period of 1990- Christmas 1992 outlining incidents which occur seemed also to raise the question that if there was so much concern why was it left to such a late date to be brought to our attention.

It was recognised that [REDACTED] are not getting younger and may be to all intents and purposes putting themselves under undue pressure in their efforts in caring for children who to say the least are extremely demanding. The consensus of opinion was that contact would be made with [REDACTED] regarding the content of their report pertaining to [REDACTED] and to this end Pat Conaty undertook to discuss the matter with Ms. Greaney with a view to visiting [REDACTED] and also eventually visiting the [REDACTED]

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FAMILY: _____

ADDRESS: _____

DATE:

18/2/1993	Letter to _____ asking to meet with her _____ and the Unit Supervisor on 28.1.1993
28.1.1993	Met with _____ Ms. Greaney and the report as submitted to the _____ Day Unit was gone through in full detail. In relation to the report submitted by the Unit the following points were raised for clarification i.e.
12.7.1991	According to the Unit staff a medical was not considered necessary due to the age, transport and general demeanour of the child.
28.11.91	It was considered that no medical was required and instead a message went home to the _____ family with the child which was "no response". Apparently any communication between the Unit, the _____ or the _____ is done by way of a notebook which the child carries in her bag.
10.1.1992	Another mark just noticed.
24.2.1992	No medical message by way of the notebook
31.3.92	No medical and a message by way of the notebook
22.7.92	As above
7.9.92	Concern was expressed by Ms. Greaney and I regarding the allegation of a bite and this was not considered to be an animal bite but more like another child's bite which would be compatible with the child's behaviour and given that she does travel by bus with other similar like children.

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FAMILY: _____

ADDRESS: _____

DATE:

1.1.1992

In relation to the comment on the report about increased concern of [REDACTED] welfare it was confirmed by the Unit staff that [REDACTED] did go to discuss this matter with the [REDACTED] family.

1.1.1992

In relation to finger mark pattern of bruising to right cheek no medical appeared necessary according to the staff at the unit, instead a note went with the child.

3.12.1992

In relation to the child seeing a Doctor the Doctor was considered by the Unit to be [REDACTED]. It was also noted by the staff particularly in relation to the last paragraph of the report that the unkempt and personal appearance of [REDACTED] was evident for the last three months.

In conclusion, it was the opinion of the Unit Staff that [REDACTED] is a very warm and caring person,

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ADDRESS: _____

DATE:

Arrangements were made between Ms. Greaney to meet _____
on the 8/2/1993 at 10.30 am.

Met with _____ and outlined the content of the report
as received from the _____ Day Care Unit and in relation
to the remarks of the report regarding _____ mood change and
adherence to a diet, the _____ family were able to confirm that
they had discussed this in detail with Mrs O'Keeffe and the diet
was strictly adhered to, in fact, they had a diet list hanging in
the kitchen and her diet book was also carried in her school bag.

In relation to April 1991, relating to the allegation of _____
being observed exhibiting of food allergies and also some new
behaviours i.e. pulling up and down panties and exploring her genital
area.

The _____ had no evidence of this but could confirm that _____
has a habit when she goes to the toilet of not pulling up her pants
properly but at no time did they observe any form of genital
exploration.

12.7.1991

_____ considered nothing untoward around this date which
they could recall.

28.11.1991

In relation to any messages which came via the book _____

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ADDRESS: _____

DATE:

_____	were quite adamant that these messages as requested were adhered to.
0.1.1992	_____ recall a "sore" in _____ scalp which they treated with savalon cream and alleged that they informed the child's mother of same.
24.2.1992	Same reply as 28.4.1991 i.e. if message came home in book it was answered.
31.3.1992	As above
22.7.1992	As above
7.9.1992	According to _____ this date was a Monday and the child would have come straight from home and gone to the _____ Unit. _____ would certainly have recalled anything like a bite mark or anything resembling a bite mark and _____ informed me that she bathed _____ on Tuesday night and cannot recall noticing any bite marks.
21/9/1992	_____ do not recall anything untoward in this particular area, other than _____ not attending for a period of time.
22.10.1992	As far as the _____ are concerned in relation to this allegation they reiterate that if a note came home the same would be complied with.

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ADDRESS: _____

DATE: _____

3.12.1992 (Thursday) [redacted] cannot recall any scratch marks but they do recall [redacted] having an above average appetite which was recorded in her book as kept in her school. In relation to the last paragraph of their report [redacted] refute the allegation that [redacted] was poorly dressed and her appearance unkempt. In particular they were extremely upset about the remarks regarding matted and unwashed hair because this was something which [redacted] attended to on a daily basis and it should be noted that the child had a habit of impulsively putting for example rice in her hair. Given that the child has long hair she also has a habit of sucking her hair and at times spitting on her hands and then pushing her^{hair} back up which would give the possible appearance of matted hair but this certainly was not an indication of negligence.

[redacted] to say the least were extremely upset and baffled by the unit's allegations especially during the time they had [redacted] there was a very amicable rapport between themselves and the unit especially [redacted] They were further upset at the fact that if they^{had} known anything concerning [redacted] that she did not come clean and inform her direct of her concerns which they would gladly have discussed with her. However, it was even more distressing for the [redacted] when they were in a position to tell me that [redacted] had been in touch with them on the 4/2/1993 for a Social chat and naturally enquired about [redacted] and they^{had} were no complaints.

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DATE:

In fact, in the course of conversation [REDACTED] said that should she be going away for any period she would be possibly asking them to take [REDACTED]

According to [REDACTED] approximately two weeks ago [REDACTED] had recommended them to another family who needed respite care for a child which made the matter even more confusing for them.

In the course of conversation [REDACTED] recalled an incident when [REDACTED] returned having been home, when [REDACTED] contacted her mother, she was concerned about bruises on the child's right leg and this was clarified by way of explanation that [REDACTED] had been up on the tractor with [REDACTED] according to the [REDACTED] also informed that they had two Alsatian Puppies and [REDACTED] sometimes plays with them in the yard. According to [REDACTED] [REDACTED] also remarked that the pups had made ribbons of [REDACTED] clothes.

In conclusion, [REDACTED] was a registered foster child minder with [REDACTED] Manchester to care for 4 children (mixed) for at least 20 years.

She returned to her local area around 1979 and approximately around 1980 she started caring for local children.

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Around the mid 80's on the advice of a local Social Worker (Married locally), [REDACTED] expressed a wish to continue caring for children and was advised by this ex Social Worker [REDACTED] that she should contact Martina Doyle and from here a break away scheme was started whereby the family having been visited and introduced to the [REDACTED] family by Martina Doyle respite care ensued and this continued apparently up to 1990 when [REDACTED] became long term. The South Eastern Health Board also have a child placed on a long basis with [REDACTED] and they also care for an adult on alternate weekend from [REDACTED]

To my knowledge and to Ms. Greaney's knowledge our Department have had at no time received any complaints from anybody prior to the present situation and in the circumstances pending an outcome we advised that [REDACTED] do not take any new children and they welcomed this. They did say they intended contacting the [REDACTED] family and also requested a copy of the report as submitted by the [REDACTED] Day Care Unit.

[REDACTED] would naturally like to see [REDACTED] notebook to confirm their personal concerns regarding the allegations made to them, i.e. of no allegation. I undertook to contact the [REDACTED] Day Unit for our own information and also to clarify these points.

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FAMILY: _____

ADDRESS: _____

DATE:

They are very very hurt that _____ would not come to them and feel genuinely for _____ and expressed a love for her. They equally expressed sympathy should _____ be going through any domestic problems assured us that if it was a question of money they had in the past told her that they would disregard the financial issue.

However, in the light of the above, sadly, it is going to lead to a very unpleasant situation between the _____ and _____. It was pointed out to the _____ by Ms. Grenney and I that we would be contacting the _____ family to see their side of the situation.

SOCIAL WORK CONTACT SHEET

PAGE: 13

34

FAMILY: _____

ADDRESS: _____

DATE:

8/2/1993

I rang the [REDACTED] household which was answered by [REDACTED] who told me that [REDACTED] and her husband were very good to [REDACTED] and his wife is extremely upset about the whole thing. [REDACTED] then came on the phone and wanted to know who mentioned her name and I advised that it has been brought to our attention by her Social Worker and the [REDACTED] Unit. She told me that [REDACTED] had been in touch with her. I said I would rather not discuss the situation over the phone but we did arrange a date whereby Ms. Greaney and I would visit on 11/2/1993.

11/2/1993

Visited the [REDACTED] household with Ms. Greaney and met with [REDACTED] who had present their legal advisor [REDACTED]

It was a tense atmosphere.

[REDACTED] was very anxious to point out that she only passed on to Martina Doyle the concerns the [REDACTED] Unit expressed to her and it was because of the advice given to her by the [REDACTED] Unit to remove her child from the [REDACTED] that she did so but because of the esteem and respect which both her husband and herself had for the [REDACTED] coupled with the fact that they were aware that the [REDACTED] were genuinely loving and caring to their child that she did not accept the gravity of the concerns put forward, hence she replaced the child back with [REDACTED]

SOCIAL WORK CONTACT SHEET

PAGE: 14

35

FAMILY: _____

ADDRESS: _____

DATE: _____

I outlined various points made which warrant clarification and in particular the comments of the 7/9/92 relating to a bite mark which I informed those present had been brought to my attention by [REDACTED] that this was at a weekend and the child had come from home to school; from there to [REDACTED] and [REDACTED] did not notice any bite mark. I was happy in so far as that it was not an animal like bite but [REDACTED] was anxious since the bite mark was noted that the school did not inform either him or his wife given that they had noted this on the 7th. [REDACTED] did point out that [REDACTED] has a habit of biting her hand when in a temper.

In relation to the suggestion of the child attending school unkempt and her hair being matted, [REDACTED] could corroborate the [REDACTED] story that she has a habit of sucking her hair and impulsively putting food also in her hair. Both [REDACTED] went on to point out that they considered that their daughter was extremely happy with the [REDACTED] and regreted the entire situation. In conclusion it appears that [REDACTED] acted on the advice of the Unit in conjunction with the Social Worker Ms. Martina Doyle.

The family are satisfied that their daughter [REDACTED] got proper care and attention and love from the [REDACTED] family and whilst respecting the views and standards of the [REDACTED] Unit as the mother knowing the condition and behaviour patterns of her daughter

SOCIAL WORK CONTACT SHEET

PAGE: 15

36

FAMILY: _____

ADDRESS: _____

DATE: _____

_____ did not feel it justified stoppage of _____ going to
 _____ respected and did not wish to hurt the
 _____ making any complaints especially since she had no reason to
 be as a mother and the legal guardian of her daughter unduly
 concerned.

The family were naturally anxious to know what the situation is
 now and we advised that we would clarify the situation with the
 _____ family since they maybe of the opinion that it was
 _____ who was making the allegations and the _____ family
 were very anxious that this be done and to this end Ms. Greaney and
 I undertook to contact the _____ family.

I undertook to get a copy of the notebook which went to and fro
 with _____ between the families to clarify the items outlined

11/2/1993

Letter to _____ requesting notebook relating to items
 mentioned in her report dated 12/1/1992 especially in relation to
 items mentioned commencing 28/11/1992 relating to "same queried
 with no response"

18/2/1992

Letter from _____, Unit Director _____ Day
 Unit in response to my letter of 11/2/1993 pointing out that they
 do not retain the notebooks as anything of a daily significance
 pertaining to each child is entered into the unit report book.

SOCIAL WORK CONTACT SHEET

PAGE: 16

37

FAMILY: [REDACTED]

ADDRESS: [REDACTED]

DATE:

22/2/93

[REDACTED] visited by Ms. Greaney and Pat Conaty.

Following the meeting with [REDACTED] of 8/2/93 contact has been made with [REDACTED] who were extremely upset. [REDACTED] has been in touch with the [REDACTED] Family on various occasions and despite acrimony the [REDACTED] genuinely care for [REDACTED] and the [REDACTED] family accept this.

As promised to the [REDACTED] I outlined to the [REDACTED] family that the [REDACTED] only acted on the advice of the [REDACTED] Day Unit.

[REDACTED] was anxious that it should be noted that the child travelled by bus and it must be respected that whilst these are "grey areas" they should be noted. The family were equally disappointed that the notebook as requested from the [REDACTED] Day Unit was not available.

[REDACTED] had an insurance policy with the [REDACTED] but since 1993 the Health Board cover foster children. The family remain members of the [REDACTED]

In conclusion and following discussion, the present situation is [REDACTED] care for [REDACTED] aged 14 full time, [REDACTED] on alternate weekends from [REDACTED]

SOCIAL WORK CONTACT SHEET

PAGE: 17

38

FAMILY: _____

ADDRESS: _____

DATE: _____

It is felt with respect to _____ age this is
sufficient. However, given the bond between _____
and the _____ family this should not be further broken in light
of enquiry and until such time as alternative arrangements be
made by _____ family the situation should continue.

Should _____ be requested to provide care for anybody
else this should be notified to the Health Board office.

However, in light of the absence of the "referred to" notebook
the family are extremely unhappy and will continue to be unhappy
until the _____ Unit can give a satisfactory answer/ an area
which the _____ family intend pursuing.

SIGNED: _____
P. Conaty,
Senior Social Worker

FSR - Volume 6

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FSR – Volume 5 - Freedom of Information

1. Introduction

- 1.1 The matters reported upon in this Volume concern the facts surrounding the processing of and response by the HSE to Grace's mother's request for documentation under the Freedom of Information Acts. In particular, it will focus on the reasons why documents on foot of that request were not provided to Grace's mother for a period of two years.
- 1.2 Given the timescale of the events relevant to this Volume of the Commission's Final Substantive Report, there is a natural overlap with chapters of other Volumes of that Report relating to Grace's life between 2008 and 2009. Though this Volume will, out of necessity, refer to some of the events covered in other chapters, findings in relation to Grace's life during that period will be made in those other chapters. This Volume will be concerned with the scope defined below.
- 1.3 The term "Freedom of Information" may be abbreviated to "FOI" throughout this Volume of the Commission's report, in particular from Section 6 onwards, below.

2. Scope

- 2.1 **Part IX a)** of the Commission's Terms of Reference requires to the Commission to:

"Establish the facts relating to the SEHB/HSE's interactions with Grace's mother from her birth until 17th July 2009, including the provision of relevant information to her in respect of her daughter's care. This should include the facts surrounding the processing of and response by the HSE to Grace's mother's request for documentation under the Freedom of Information Act and in particular the reasons why documents on foot of that request were not provided to Grace's mother for a period of two years."

This Volume will focus solely on the second aspect of that term of reference, that being the *"processing of and response by the HSE to Grace's mother's request for documentation under the Freedom of Information Act and in particular the reasons why documents on foot of that request were not provided to Grace's mother for a period of two*

years.” Matters relating to the SEHB/HSE’s interactions with Grace’s mother from her birth until 17th July, 2009 have already been reported upon in the First and Second Substantive Interim Reports and are also reported upon in the Commission’s Final Substantive Report.

3. Methodology

- 3.1 The methodology adopted by the Commission to gather in all relevant records and documentation with respect to this particular Term of Reference is set out elsewhere in this report.

4. Witnesses

- 4.1 The following people provided evidence to the Commission on the matters reported in this Volume:

- Ms B;
- Ms Jacinta Brennan;
- Ms Margaret Browne;
- Ms Sinéad Byrne;
- Mr. Graham Farrell;
- Mr. Dermot Halpin;
- Mr. Gerry Maley;
- Mr. Iain Smith;
- Mr. Fergal Walsh; and
- Mr. Pat Walsh.

- 4.2 Grace's mother, who resides outside the jurisdiction of the State, did not give evidence to the Commission. When the Commission commenced its work, Grace's mother's provided it, through her solicitors, with copies of the documentation in Grace's case that she had received from the HSE in 2010 pursuant to a freedom of information request she had made.
- 4.3 The manner in which the Commission conducted hearings is fully set out in the methodology chapter. As a result of the Covid-19 pandemic, and the restrictions in place as a result of it, some hearings relating to matters relevant to this Volume were held utilising teleconferencing software. The Commission is satisfied that this was an effective method for the conduct of some of the Commission's hearings in the circumstances prevailing.
- 4.4 Most of the witnesses who gave evidence in relation to this Volume have given evidence in relation to other aspects of the Commission's investigation and their roles have been already set out in Volume 1 of the Commission's Final Substantive Report. The specific roles of Mr. Fergal Walsh and his manager, Ms Sinéad Byrne with respect to the processing of freedom of Information requests are described below.
- Mr. Fergal Walsh (hereafter referred to as "Mr. F. Walsh" in order to distinguish him from the Acting General Manager in Waterford Community Care, Mr. Pat Walsh, who, for the purpose of this Volume, will be referred to as "Mr. P. Walsh") was, at the time relevant to this Volume of the Commission's report, a Research Officer in HSE South's Consumer Affairs Department – Freedom of Information. He joined the HSE in 1993 in the Information Communication and Technology Department and transferred from that department to the general administration area and then into the Consumer Affairs Department in 2003. Mr. F. Walsh told the Commission that he had no previous experience in relation to freedom of information prior to joining the department but that he received on the job training, supplemented with courses in relation to the implementation of the Freedom of Information and Data Protection Acts. Mr. F. Walsh told the Commission that he would deal with approximately 50 to 60 freedom of information requests each year at this time.
 - Ms Sinéad Byrne, at the time relevant to this Volume of the Commission's report, had been working in the area of freedom of information since 2002, when she was appointed as the Freedom of Information Officer for the South

Eastern Health Board. In 2003, following an amendment to data protection legislation, she became the “*data controller*”. After the amalgamation of HSE South and HSE South East in 2007, Ms Byrne held the regional role of Consumer Affairs Manager. This post covered the entire southern end of the country. Ms Byrne told the Commission that this role was responsible for more than just freedom of information and included complaints and appeals under consumer affairs, as well as freedom of information and data protection matters. Ms Byrne said that she performed a dual role at the time as a result of the fact that the HSE did not fill her previous post when she took on the regional role and, as a result, she maintained a more “*hands on*” role in the South East area. Mr. F. Walsh, who was managed by Ms Byrne, was one of two research officers working under her at the time.

5. Background

The legal framework

- 5.1 During the period relevant to this Volume, that being approximately July, 2008 to July, 2010, the accessing of information from public bodies such as the HSE was principally addressed under the Freedom of Information Act, 1997 (generally referred to hereafter as “the 1997 Act”), as amended. The Freedom of Information Act 1997 and the Freedom of Information (Amendment) Act 2003 were subsequently repealed by the Freedom of Information Act 2014. Some pertinent sections of the 1997 Act, as amended, are set out for ease of reference in the Appendix to this Volume.

6. The roles of staff members upon receipt of a freedom of information request

The Consumer Affairs Department

- 6.1 From 2008 to 2010, FOI requests were dealt with by the Consumer Affairs Department in the Health Service Executive which was led by the manager, Ms Byrne. Under Ms Byrne were two research officers, one of whom was Mr. F. Walsh, the officer relevant to the events covered by this Volume of the Commission’s report. Each of the research officers covered a particular geographic area.
- 6.2 Both Ms Byrne and Mr. F. Walsh gave evidence in relation to the manner in which requests were routinely processed. Ms Byrne told the Commission that, during this

period, the Freedom of Information Unit¹ was dealing with *“a couple of hundred FOI requests every year in relation to complex social work matters.”* The tasks carried out by her Unit under the 1997 Act were tasks delegated to it.

- 6.3 Ms Byrne told the Commission that often when a FOI request was received in the Consumer Affairs Department, it would be immediately obvious as to whom the request should be forwarded. She offered an example whereby an applicant would seek their files from Wexford General Hospital and her Unit would simply forward that request to the relevant hospital. She said that in circumstances like those in Grace’s mother’s request, where a request would be received by her Unit seeking all files relevant to a certain individual, she would assign the case to either of the two research officers who worked under her. Ms Byrne told the Commission that her involvement thereafter would be supportive and would include discussing the case with the research officers, if required.
- 6.4 Mr. F. Walsh told the Commission that when a case was assigned to him by Ms Byrne, it would be logged on the system. He said that the date that the request was received was important as, under the legislation, the responses were time driven. The types of records that were requested were sought from the relevant record holder, such as a government department. In the case of a government department, contact was made with the secretary there. Next, a copy of the request would be sent to the relevant department stating that the files were needed and asking that they be sent or made available for collection. Mr. F. Walsh said that when the files were delivered to him, the date upon which they were received would be logged on the system. Each page of every file was numbered and it was then copied. The original files would be sent back to their original office and the copies would then be worked on in Consumer Affairs. Mr. F. Walsh would then read the files to determine which records could or could not be released under the legislation.
- 6.5 On a practical basis Mr. F. Walsh told the Commission that when a file came in, two copies of it would be made. He said that one would have been left clear so the original record could be seen, whereas the second copy might contain redactions, if necessary, under the Act. Mr. F. Walsh said that both files would be presented to the decision-maker to allow him or her to come to a decision with regard to the release of documents. Mr. F. Walsh said that the schedule would contain a list of the documents

¹ The terms “Unit” and “Office” were used interchangeably in the evidence when describing this body, which will generally be referred to as the “FOI Unit” in this Volume.

to be released/omitted, whether redaction was necessary, and the section of the Act under which the decision was made in relation to each document.

- 6.6 In terms of communication with the applicant, Mr. F. Walsh said that this would vary depending on the individual case. He said that the first action that would be undertaken in any case would be that of sending a letter to the applicant on the day that the request was received or the following day, stating in it the date that the request was received and that a decision would be made within 20 working days. This was to be done in accordance with s. 7(2) of the Act. Mr. F. Walsh said that this was a *pro forma* letter sent by the Unit. He had not drafted it and believed that it had already been in use prior to his commencement in his role.
- 6.7 Mr. F. Walsh told the Commission that “*sensitive*” cases were not treated differently or in a different category because the research officers’ role was to prepare the records for potential release and present them to the decision-maker, who was usually a general manager of the relevant department. As research officers, they were preparing the release for his or her decision and when the time came for the records to be released, they would arrange to meet with the decision-maker or have the files sent to him or her, with their draft decision letter written and space for his or her signature. If there were any queries in relation to particular issues, the decision-maker would come back to the research officers directly on them.

The decision-maker

- 6.8 According to the evidence collected by the Commission, the ultimate decision-maker, with regard to a FOI request, would be the general manager of the department from which the records were sought. Mr. F. Walsh told the Commission that while he would go through the records and advise which records should or should not be released under the legislation, the ultimate responsibility for determining what records would be released rested with the decision-maker. As of July, 2008, Mr. P. Walsh was the Acting General Manager of the Disability Services in the Waterford Community Care area and, thus, he was the *de facto* decision-maker with regard to Grace’s mother’s FOI request.
- 6.9 Mr. P. Walsh told the Commission that the role of “*decision-maker*” came with his job as General Manager. He said that while he was not aware of the precise details of the FOI legislation, he was familiar with his obligations as decision-maker. With regard to

the specific provisions under the legislation, Mr. P. Walsh said that he was reliant on being guided by the Freedom of Information Office (Consumer Affairs), though he said that he was aware that there were general time limits to which adherence was required. He was also aware that provisions existed relating to extensions of time, for a period of up to eight weeks.

6.10 Mr. P. Walsh said that he knew that there was an obligation under the Act to acknowledge a FOI request in writing. He said that he was not aware, at that time, of what specifically a requester was required to be told and said that *“communications would have issued from our Freedom of Information Office or Consumer Affairs [Department].”* Mr. P. Walsh was unfamiliar with the concept of a “deemed refusal”, as provided for by s. 41 of the Act, referred to further below.

6.11 Mr. P. Walsh said that, ordinarily, the process in relation to FOI requests was that they would be *“routed directly in through our Freedom of Information Office”* and *“it’s really at the latter stages of it that I would get involved in terms of the decision.”* He told the Commission that, at the time, he would not have had an involvement in ensuring adherence to statutorily imposed time limits. He said that although, as decision-maker, he *“probably”* had a responsibility in that regard, he would not have been *“actively pursuing them or chasing them”*, meaning the Consumer Affairs Department, which was, as a matter of practicality, managing the request.

6.12 Mr. P. Walsh told the Commission that Grace’s mother’s request was the first FOI request for which he was the “decision-maker” since coming into the role of General Manager in July, 2008.

The decision-reviewer

6.13 Section 14 of the 1997 Act provided for reviews of decisions by heads of departments. According to s. 14(3) of the Act, a person delegated to make a decision under s. 4 of the Act in respect of the initial FOI request could not make the decision with regard to a s. 14 review. Instead, the decision in that review had to be made by a person of either the same or higher rank than the initial decision-maker.

6.14 Mr. Dermot Halpin was the Local Health Manager in Waterford Community Care. He was also Mr. P. Walsh’s immediate superior and was thus the appropriate person to conduct a review of a FOI request decision. Mr. Halpin’s role with respect to FOI

requests only crystallised upon the request for a review of the initial decision made under s. 7 of the Act.

- 6.15 Mr. Halpin told the Commission that upon receiving a request for an internal review, his first action would have been to acknowledge the letter in writing. Following that, Mr. Halpin said that he would review the case to ascertain “*what the position was in relation to it.*” He said that either he or someone from his office would have done this by contacting the office which made the original decision. Mr. Halpin told the Commission that if someone was making a complaint, “*they’re looking for a remedy*”, and that that would have been his focus. This is referred to later in this Volume.

7. Grace’s mother’s freedom of information request

Introduction

- 7.1 As mentioned above at paragraph 1.2, there is an overlap between events relating to Grace’s mother’s FOI request and events relating to the management of Grace’s life and care in general during this period. As can be seen in other Volumes of this Final Substantive Report, the period from 2007 to 2009 was an exceptionally busy one in terms of Grace’s life and her care. While this Volume will not be focusing on Grace’s care, it will be necessary at some points to provide context to the events relevant to this Volume by reference to events and actions relating to the management of her case. With the exception of two witnesses whose sole involvement relates to Grace’s mother’s FOI request, all the HSE witnesses relevant to this Volume had a role in the management of Grace’s case.
- 7.2 As discussed in great detail in Part 1 of Volume 1, by the starting point of this Volume in June, 2008, dialogue had opened between the HSE and Grace’s mother. Mr. Iain Smith, Social Work Team Leader in Disability Services working with vulnerable adults, had written and disclosed his draft social work report about Grace to his co-workers, the HSE had sought legal advice, and the Vulnerable Adults Committee (hereafter “the VAC”) was considering ways in which to remove Grace from Mrs. X’s home.

Origins of Grace’s mother’s freedom of information request

- 7.3 The starting point with respect to the events reported in this Volume begins with a letter from Mr. Smith to Grace’s mother, as set out below.

- 7.4 On 18th June, 2008 Mr. Smith drafted a letter to Grace's mother in which he told her that he had looked into Grace's circumstances. He stated that Grace was a vulnerable adult and had been referred to the VAC, which had recommended that she be moved to a new placement which, he said, would be "*very suitable*" for her.
- 7.5 Mr. Smith went on in his letter to "*strongly encourage*" Grace's mother to contact him so that they could arrange to meet up and discuss his own assessment of Grace's situation. He noted that she might be unaware of information pertaining to Grace and told her that she could access it under FOI, which he "*strongly urge[d]*" her to do, enclosing a letter for her to send to the HSE in that regard. Mr. Smith stated that he was advocating that course of action on account of Grace's "*very great vulnerability*" and expressed the view that if she was better informed about Grace's situation, she would wish to do more in planning her care.
- 7.6 Mr. Smith also told Grace's mother in his letter that it was unclear whether her consent would be sufficient to allow Grace to be moved from Mrs. X. He said that Mrs. X strongly opposed the move and wanted Grace to remain with her. Mr. Smith said that, as on previous occasions, she would "*oppose any attempts by the Health Service Executive to remove her*", and that Grace had been left in an "*unprecedented legal grey area*". He told Grace's mother that if she was more involved, matters might be more easily resolved in Grace's best interests.
- 7.7 Mr. Smith told the Commission that he had taken the draft letter with him on his home visit to Grace and Mrs. X on 23rd June, 2008 and, having seen Mrs. X's opposition to Grace's removal, he posted it to Grace's mother immediately afterwards.
- 7.8 Explaining his actions in evidence, Mr. Smith told the Commission that at this time there were a number of options as he saw them. One was to do nothing, which he did not think was acceptable; another was to wait until they finally got the legal advice they had been looking for, which he said "*had been problematic*"; and another was to contact Grace's mother and invite her into the process.
- 7.9 Mr. Smith explained his contact with Grace's mother by reference to her request for information and what he termed the "*refusal*" of the VAC to follow his recommendations. He described his letter to Grace's mother as "*a further step that I took when it looked like the HSE wasn't going to be making the application that I was recommending.*"

- 7.10 Mr. Smith said that it appeared that *“whichever way this was going to go [Grace’s mother] needed to be involved in this process. I was writing a letter which tried to strike a balance between stating the situation as plainly as I could without causing huge distress to [Grace’s mother].”* He said that if they were not going to court, at least Grace’s mother would have *“some sort of say”*, adding that *“it was a question of inviting her into the situation... in a way as not to cause unnecessary distress”*. He said that *“this really was a delicate situation if ever there was one.”* Mr. Smith said that he envisaged offering to meet with her if she contacted him, showing her some of the files, and talking to her about the fact that some of the information on them would, in his view, be quite distressing.
- 7.11 Mr. Smith explained that he was of the view that there would be an issue with Mrs. X’s opposing Grace’s removal from her care, which had led to past efforts to remove her *“run[ning] into the sand”*. He said that he was trying to suggest in his letter that Grace’s mother needed to become involved in order to prevent that happening. He characterised what he was suggesting as *“sound practice”*, being *“just hitting the bare minimum of acceptable practice”*. He reiterated in his evidence that *“best practice”* would have been to have recourse to the courts.

Ms Browne’s and Mr. Maley’s reaction to Mr. Smith’s letter to Grace’s mother

- 7.12 On the morning of 1st July, 2008, Ms Browne emailed Mr. Smith, copied to Ms Brennan and Mr. Gerry Maley, Children and Family Principal Social Worker in Waterford Community Services, asking that he refrain from writing to Grace’s mother. She learnt from Mr. Smith later that day that he had already sent that letter on 23rd June, 2008 the day before the VAC meeting on 24th June, 2008. Ms Browne asked him for a copy of it.
- 7.13 In her evidence, Ms Browne said that their view was that they would have a *“supportive role”* with Grace’s mother and that there was a feeling that Mr. Smith’s letter *“wasn’t in the spirit of what we were planning...”* There was no reference to his proposed course of action in the VAC minutes and Ms Browne did not recall Grace’s mother’s making a FOI request ever being discussed at the VAC meetings by that stage.
- 7.14 Ms Browne said that, by copying her email to Mr. Maley, she was looking for *“clinical guidance”*, although this was not specifically requested of him. Mr. Maley had no recollection of receiving Ms Browne’s email but told the Commission in any event that

he would have questioned why he was copied on it. He said that he viewed the VAC as the “*decision-making forum for vulnerable adults*” and that his reaction to Ms Browne’s email would have been that it was an “*operational matter for [Ms Browne], not an issue for me, move on, deal with the children[’s] and families[’] issues that I was dealing with.*” He said that he would not have intervened in relation to the letter which Mr. Smith had sent Grace’s mother because, as far as he was concerned, it was a case management issue coming from the VAC.

- 7.15 Mr. Maley also pointed out at the Commission that he did not see himself as having a full line management role or a full supervision role *vis-à-vis* Mr. Smith, but only an “*oblique kind of line management and partial supervision*”. Mr. Maley explained that he did not allocate tasks to Mr. Smith, read his referrals, scan or allocate his work, or review his case load.
- 7.16 Mr. Maley met with Ms Browne and Mr. Smith on 1st July, 2008. In relation to Grace’s mother’s FOI request he recalled that Ms Browne was unhappy about Mr. Smith’s letter and that there was a sense that it was “*somehow inappropriate*” and “*wasn’t the right thing to do.*” He said that he had a sense that Mr. Smith had acted unilaterally in sending the letter and that it was not a decision of the VAC. Mr. Maley indicated that, around this time, he checked with a team leader in child protection if such a letter would issue as matter of course and was told that it would not. According to Mr. Smith’s note of the meeting, Mr. Maley told him that giving clients details of freedom of information legislation was not something he would do in every case. However, Mr. Smith replied that Grace’s case was “*not every case*” and said that his letter to Grace’s mother was in line with the code of ethics applicable to him as a social worker.
- 7.17 According to Mr. Smith’s note of the meeting, Ms Browne was “*very disturbed*” by his letter to Grace’s mother, particularly in relation to urging her to seek files under freedom of information legislation, and she said that Grace’s mother was a “*very vulnerable woman*” who would not be able to cope with that. Ms Browne confirmed in evidence that she “*wasn’t happy*” that Mr. Smith had written to Grace’s mother in that regard without consulting anyone. She said that she was concerned that it might compromise their plan for Grace and upset Grace’s mother. Ms Browne also said that part of her concern was that she did not know what had motivated Mr. Smith to write to Grace’s mother, and she queried whether he was trying to compromise or stop the consents obtained from her. She said that she wanted to see what Mr. Maley thought.

- 7.18 In the light of a growing sense of a personal issue between Mr. Smith and Ms Browne, Mr. Maley said in evidence that he remembered trying to remain objective and impartial during the meeting by saying that he could “*kind of see both sides*”. He recalled saying “*we wouldn’t do it [send such a letter] every time.*”

Ms Browne writes to Mr. Halpin

- 7.19 On 3rd July, 2008, Ms Browne emailed Mr. Halpin about Grace’s case. She told Mr. Halpin that another complication, in addition to other matters not relevant to this Volume, was “*a letter which has been sent to the client’s mother*”, which was a reference to the letter which Mr. Smith had written to Grace’s mother. Ms Browne stated that Grace’s mother “*had given consent based on a specific amount of information given to her*” and she expressed the hope that she would not withdraw or delay the consent for Grace’s move to a residential placement. She said in evidence that that was not her “*sole view*” but was based on “*comments from others*” and discussions she had with others. Ms Browne’s evidence was that the basis of her concern in that regard was that Grace’s mother might discover more information if she proceeded with the FOI request. However, in the course of her evidence, and suggesting that she might be contradicting herself, she said that she thought that if Grace’s mother obtained that information about Grace, she would be even more likely to want her to go into residential care.
- 7.20 Ms Browne said that she did not think that she had thought about how Grace’s mother’s FOI request might reflect on the HSE and the South Eastern Health Board, or that that had been in her mind when she spoke to Mr. Graham Farrell, solicitor, back in March, 2008 as reported in Part 1 of Volume 1. Of course, Mr. Smith had not sent the letter to Grace’s mother at that stage. While saying that they were all aware that there were “*difficulties*” with the HSE, in her evidence, Ms Browne stated “*categorically*” that it had never stopped her doing anything she felt was in Grace’s best interests.
- 7.21 Ms Browne agreed, however, that Grace’s mother had not been told about any of those “*difficulties*” during any of the communications she had had with her leading to her giving consent, even though they did not fall within the information which Mr. Farrell had advised should not be given to Grace’s mother, such as decisions made at the case conference in October, 1996 and the fact that Grace had not had a visit from 2001 until 2007. While Ms Browne said that she did not see any reason why Grace’s mother could not have been told about them and was unable to say why she had not mentioned

them to her, it was clear to the Commission that Ms Browne made a decision not to relate such information to her. The issue of whether or not Grace's mother provided informed consent to Grace's potential move in April, 2008 (leaving aside the question of whether a consent provided any legal authority to the HSE) is considered in Part 1 of Volume 1.

- 7.22 Ms Browne concluded her email to Mr. Halpin by saying that "[t]ime is of the essence" and sought to discuss the matter as soon as possible.

Ms Brennan's and Mr. Halpin's reaction to Mr. Smith's letter to Grace's mother

- 7.23 Ms Brennan wrote to Ms Browne on 3rd July, 2008 to say that she had received the letter that Mr. Smith had sent to Grace's mother. Ms Brennan told the Commission that the sending of the letter worried her and that she questioned why it had been sent. She believed it would have been *"better to do it in a meeting face to face"* and was concerned about the *"emotional effect that would have on a mother receiving that in writing."* Adverting to the step-by-step approach they were taking and what she said were their efforts to be *"very sensitive"* to Grace's mother, Ms Brennan said in evidence that she did not think that the sending of the letter was *"in tandem with what we would have agreed in the step-by-step approach."*
- 7.24 An annotation on a copy of Mr. Smith's letter to Grace's mother asked that it be copied to *"D. Halpin, J. Brennan G. Maley"*. Mr. Halpin told the Commission that he could not recall when he received that letter but thought that he became aware of it at this time or later on. He said that Mr. Smith's suggestion that Grace's mother utilise the FOI process did not give him any cause for concern. However, he said that the contents of Mr. Smith's letter seemed to be *"going astray"* from the path at that point, which was to progress using Grace's mother's consent, which he said was now being *"possibly undermined."*

Submission of FOI request

- 7.25 Using the letter Mr. Smith provided, on 30th July, 2008 Grace's mother wrote to the Freedom of Information Officer in Kilcreene Hospital, Kilkenny requesting that she read the files for her daughter Grace. It was received there on 1st August, 2008. Her letter, a draft of which had been provided to her by Mr. Smith, read as follows:

"Dear Sir/Madam,

I am writing to request formally that I read the files for my daughter [Grace].

[Grace] was in the care of the South Eastern Health Board nearly all her childhood, where she came under the supervision of the Waterford Office.

[Grace] has a profound intellectual disability and I understand that her files are held in the offices of the Waterford Community Services Disabilities Team.

I look forward to hearing from you,

Yours sincerely,

[Grace's mother]"

Processing of FOI request

Request received by research officer

- 7.26 Grace's mother's letter made its way to Mr. F. Walsh who was, as referred to earlier, the research officer in the HSE's Consumer Affairs Department – Freedom of Information. Mr. F. Walsh told the Commission that the request would have gone first to his manager, Ms Byrne, who then assigned it to him. Mr. F. Walsh explained that it was his role as research officer to log the matter on the system with the date that it was received and then to obtain and prepare the records for release, with the decision-maker usually being the General Manager.
- 7.27 Upon receipt of a request, a standard acknowledgment letter would be generated and sent to the requester. When the time came for the release of the documents, a meeting would be arranged with the General Manager, to whom the records would be sent, along with the decision letter for him to sign, if the General Manager was minded to release the records.
- 7.28 Section 8(1) of the 1997 Act provided that a decision was to be made on the request not later than four weeks after it was received. Mr. F. Walsh noted that the date on

which the request was received was therefore important as the response was *"time driven"*.

- 7.29 No-one had spoken to him about Grace's mother's request before he saw it, nor was he aware of the circumstances in which the request had been triggered. Mr. F. Walsh told the Commission that her request did not strike him as being in any way unusual.

Entitlement of Grace's mother to seek files in relation to Grace

- 7.30 Grace's mother's entitlement to make a FOI request was governed by the Freedom of Information Act 1997, Section 28(6) Regulations 1999 (S.I. No. 47 of 1999), reg. 3(1) of which provided:

"Notwithstanding Section 28(1), a request under Section 7 in relation to a record access to which involves the disclosure of personal information (including personal information relating to a deceased individual) shall, subject to the other provisions of the Freedom of Information Act, 1997, be granted where:

(a) the requester is a parent or guardian of the individual to whom the record concerned relates and that individual belongs to one of the following classes of individual:

...

(ii) individuals who have attained full age (within the meaning aforesaid), who at the time of the request have a mental condition or mental incapacity or severe physical disability, the incidence and nature of which is certified by a registered medical practitioner and who, by reason thereof, are incapable of exercising their rights under the Act, being individuals specified in clauses (i) and (ii) access to whose records would, in the opinion of the head having regard to all the circumstances and to any guidelines drawn up and published by the Minister, be in their best interests ..."

- 7.31 Mr. F. Walsh told the Commission that he would have dealt with very few requests for information from the parent of an adult. He was not aware of the Regulations of 1999.

Although unfamiliar with the legislative requirements, his view was, essentially, that Grace's mother was entitled to make the request because she was Grace's mother, because Grace was in the care of HSE and had no capacity, and because it was in the best interests of Grace.

- 7.32 Mr. F. Walsh said that he did not query the legitimacy of the request with anyone in the Unit, notwithstanding the fact that Grace was an adult. That did not arise, he said, *"because the records were being held by the care service provider and the parent was acting on behalf of the child we wouldn't have been able to make a decision on that until we would have seen the records"*. Nor did he seek any legal advice on the matter. He said that the statement in the letter from Grace's mother that *"[Grace] has been in the care of the SEHB nearly all of her childhood, where she came under the supervision of the Waterford office"* suggested to him that the initiation of the request was legitimate. He said that on reading the records, it would have become clear that Grace was not in a position to request the records for herself and that he would have thought that her mother would have been acting in her best interests.
- 7.33 In considering the evidence relevant to establishing *"the facts surrounding the processing of and response by the HSE to Grace's mother's request for documentation under the Freedom of Information Act..."* Grace's mother's entitlement to the documentation sought was not an issue that arose for consideration, on the evidence provided to the Commission. The Commission is satisfied that Grace's mother's entitlement to make such a freedom of information request was neither considered nor disputed at any stage over the period that this request was being processed within the HSE.

Mr. F. Walsh sends FOI request to disability services

- 7.34 On 7th August, 2008, Mr. F. Walsh faxed a copy of Grace's mother's FOI request to an administrative officer in disability services following a short courtesy call to her about it. She was the first person he contacted in relation to the request. He said that she would have brought the request to the attention of the most senior person in her department (in this instance, Ms Browne) to say that she needed to get the files for him, following which the files were sourced and sent on to him. The Commission notes that Mr. F. Walsh's approach here was in accordance with the norm. Mr. P. Walsh agreed that that was the case. He told the Commission that he could not recall when

he learnt of Grace's mother's request but that he would expect that it came to his attention "*relatively shortly*" after it was received.

Acknowledgment of FOI request

- 7.35 Under s. 7(2) of the 1997 Act, a letter acknowledging receipt of the request was to be sent to the requester. Accordingly, on 7th August, 2008, Mr. F. Walsh wrote to Grace's mother, thanking her for her request for access to information in respect of Grace. His letter explained that, in certain circumstances, a final decision might take longer, in which case an extension of four weeks was provided for under the legislation. His letter also outlined Grace's mother's right of appeal.
- 7.36 Mr. F. Walsh confirmed in evidence that the letter in question was the standard letter that issued to requesters following receipt of their request and had been in existence since he joined the Unit.
- 7.37 Mr. F. Walsh told the Commission that he spoke to Grace's mother at some stage about her request but he could not recall their conversation, indicating that he might have simply outlined to her what was going to happen to it. He could not recall when this occurred. Mr. F. Walsh said that his only recollection of a telephone call with Grace's mother was that it had possibly been necessary for her to use a neighbour's telephone and that he had to arrange to call her back the following day.
- 7.38 It is of note that the standard letter which issued to Grace's mother was not in accordance with the legislation because, although s. 7(2) of the 1997 Act required it to contain "*a summary of the provisions of section 41*", the letter failed to explain that, in accordance with s. 41 of the 1997 Act, there would be a deemed refusal of the request if notice of a decision was not given to her before the expiry of the time period set out in s. 8.
- 7.39 In his evidence, Mr. F. Walsh acknowledged this omission from the response. He also acknowledged that he was unfamiliar with the legal consequences of not making a decision within the time permitted by the legislation. His understanding of a deemed refusal was that if no decision had been made within the statutory time period and the records had not been provided to the requester, the requester could then launch an appeal on the basis that they had not got the notice of a decision within the time period.

7.40 Mr. P. Walsh told the Commission that this letter of acknowledgement was of the type of communication on which he would have deferred to the Freedom of Information Unit. He had no recollection of ever seeing this letter.

7.41 The Commission is satisfied that the standard letter that issued to Grace's mother in response to her request, should have alerted her to the effects of s. 41 with respect to deemed refusal of the request if notice of a decision was not given to her before the expiry of the time period set out in s. 8 of the Act, thereby giving an immediate right of appeal against the deemed refusal. The fact that this was not done was a failure of the HSE's statutory duty to Grace's mother in this process. The Commission finds that the existence of this statutory provision was simply ignored.

Mr. Smith's observations on initial response to Grace's mother

7.42 Commenting on the initial response to Grace's mother, Mr. Smith told the Commission that he was not aware of this correspondence at that time and owned to having been a bit surprised by that, given that he initiated it (which he thought Mr. F. Walsh would have known), and stated that it was "*clearly a sensitive situation.*" He indicated that he would have expected Mr. F. Walsh to have discussed it with him, saying that he had discussed other sensitive cases with him in the past. The Commission is satisfied, however, that it was appropriate for Mr. F. Walsh to respond to Grace's mother's request by an acknowledgement letter and that Mr. F. Walsh did not have any particular knowledge of the parties involved at that time.

7.43 In any event, Mr. Smith told the Commission that the important factor at this point was that he believed Grace's mother to be now engaged in a process which might lead her to an understanding of Grace's situation and, possibly, to action on her part on Grace's behalf.

Ms Browne discusses FOI request with Mr. Smith

7.44 A note made by Mr. Smith recorded that he and Ms Browne discussed Grace's mother's FOI request on 21st August, 2008 and that they agreed that they needed to speak to Mr. F. Walsh before information was released. Ms Browne did not remember that conversation but accepted Mr. Smith's record of it.

- 7.45 Ms Browne said that Mr. F. Walsh would have been aware that she knew where the files on Grace were located. Ms Browne said that she wanted to give him that information, *i.e.* that there were files in the HSE and the local voluntary association. She also wanted to let him know that there was legal advice pertaining to the sharing of information. Ms Browne said that this was the normal way to proceed and that she wanted to convey that information to him before he read the files. Ms Browne told the Commission that she would not have been giving him background information about what was on Grace's file.
- 7.46 Asked if she had any particular concern about the release of information on the files, Ms Browne said that this had nothing to do with her and that after she had imparted to Mr. F. Walsh the matters referred to in the preceding paragraph, she would have no role in the process.
- 7.47 Mr. Smith recalled that, from his perspective, they were concerned for Grace's mother. He said that he anticipated "*further upset*" and "*even anger*" in relation to information she might receive and that that was his motivation for wishing to speak with Mr. F. Walsh.

Exchange of emails with respect to FOI request – the issue of legal advice

- 7.48 On the same date, 21st August, 2008, Ms Browne emailed Mr. P. Walsh and Mr. Halpin, referring to the receipt of Grace's mother's request, which she reminded them Mr. Smith had advised Grace's mother to make. She stated that she would make contact with Mr. F. Walsh and advise that they meet before any information was released.
- 7.49 Mr. Halpin replied to Ms Browne later that afternoon, also sending his reply to Mr. P. Walsh. He stated that the request needed to be dealt with "*under Fol*" as *per* Ms Browne's "*approach*" to the matter, as he might have a role in the appeal if certain records, or all records, were not released. He said that consultation on the matter in order to arrive at a decision (on the FOI request) needed to be dealt with through Mr. P. Walsh, adding that that did not preclude overall discussion on the case itself.
- 7.50 In evidence, Mr. Halpin could not recall that exchange of emails, but said that that was the first time he became aware of Grace's mother's FOI request. He said, however, that he presumed that Grace's mother's request would be dealt with as *per* the routine,

in that the FOI Unit would obtain the files and establish what fell within the scope of the request.

- 7.51 In evidence, Mr. P. Walsh said that he did not know what Mr. Halpin meant by his reference to Ms Browne's "*approach*" to the matter, other than that it might refer to her request for a meeting or discussion with the Consumer Affairs Department. Mr. P. Walsh was unable to recall if Mr. Halpin had spoken to him about his potential appellate role, but he said that the approach referred to by Mr. Halpin would have been routine as Mr. Halpin was the internal reviewer, whereas he was the "*designated decision-maker in the process*" as regards FOI requests in respect of Waterford.
- 7.52 Meanwhile, that afternoon, before Mr. Halpin replied to Ms Browne's email, Ms Browne emailed Mr. F. Walsh asking that he make contact with her before any decision was made on Grace's mother's FOI request. Mr. F. Walsh told the Commission that he did not recollect receiving that email, which he said would not have struck him as unusual, nor could he recall any conversation with Ms Browne in relation to it.
- 7.53 Bearing in mind the limited role she had outlined herself as having in the process, Ms Browne was asked at the Commission why she had requested Mr. F. Walsh to contact her. Ms Browne referred again to Mr. Farrell's legal advice from March, 2008 that information with regard to allegations which did not involve Grace's mother should not be shared with her, describing it as "*an important piece of information*" for Mr. F. Walsh to which she drew his attention. The nature of this legal advice and the circumstances in which it was given are reported in Part 1 of Volume 1. Ms Browne described the advice as "*relevant to what information would be released*", adding: "*I was thinking about release of files rather than anything else. I was just trying to be helpful.*" She said that any decision concerning what information could be shared would be nothing to do with her.
- 7.54 The Commission considers the above position as set out in Ms Browne's evidence to be somewhat contradictory. Conveying to Mr. F. Walsh what Mr. Farrell had advised about the extent of information to be provided to Grace's mother when seeking her consent to bring Grace for assessment was, however, clearly intended to have some influence on Mr. F. Walsh's consideration of the information to be released to Grace's mother pursuant to her FOI request. This was especially the case given that Mr. F. Walsh was asked by Ms Browne not to make any decision in respect of Grace's mother's FOI request prior to speaking with her.

- 7.55 Mr. F. Walsh did recall that it was raised with him that releasing information to Grace's mother might "*hamper*" cooperation with her. He was aware of this concern but he said that that would have been a matter for Mr. P. Walsh and Mr. Halpin to consider. Mr. F. Walsh told the Commission that he did not recollect anyone, including Ms Browne and Mr. Smith, mentioning Mr. Farrell's legal advice to him and he did not recall reading any legal advice when reading the file. The Commission accepts, however, that this was conveyed to him at some stage.
- 7.56 Mr. P. Walsh said that it would not have been unusual for persons involved in the management of the files to ask to see the researcher, and that it would occur particularly if there were concerns that the requester might have a difficulty on receiving the file. He said that it might well be the case that, in those circumstances, the requester would be advised to get support or be offered support.
- 7.57 Mr. P. Walsh told the Commission that he was not sure what lay behind Ms Browne's approach to Mr. F. Walsh; however, he said that, as Coordinator of Disability Services, she would have had a role in ensuring that all the files were brought together. He said that it would not have been entirely unusual for such an approach to be made to the researcher in relation to the request, but he added that it "*certainly wouldn't be routine*" either.

Mr. Smith contacts Mr. F. Walsh

- 7.58 On the 25th August, 2008 Mr. Smith telephoned Mr. F. Walsh. His note of their conversation recorded that he outlined the circumstances and complexities of the case and emphasised the need for Mr. F. Walsh to meet with them. This was the day before a VAC meeting. His note stated that Mr. F. Walsh told him that he would need to be sent the files and that, when he had read them, he would consult with his manager, Ms Byrne, and meet with them then.
- 7.59 In evidence Mr. Smith said that he was contacting Mr. F. Walsh to tell him that he would be interested in the process. At the Commission, Mr. F. Walsh did not recollect that conversation or, indeed, any communication with Mr. Smith around that time in relation to Grace's mother's request. However, he said that an attempt to meet with him in relation to a request was not unusual, though he added that it was not normal either. He explained that if staff involved in providing information to a requester had any general queries in relation to the records, the Freedom of Information Unit would

recommend that they would raise them with the General Manager. On the other hand, if such staff had any queries that the Unit could answer, he said that the Unit would be open to discussing the particular case with them.

- 7.60 Mr. F. Walsh said that the course outlined in Mr. Smith's record of their conversation was "*quite possibly*" a normal situation. He explained that his "*general line*" was that he would always meet to discuss the request for information with a department head but that his recommendation following perusal of the files was for the decision-maker (in this case, Mr. P. Walsh).
- 7.61 Mr. F. Walsh also pointed out that if a department head did not want records released, he would not feel under pressure to comply with that. If files were eligible for release, he would make that recommendation to the decision-maker, being the General Manager, who had the final say.
- 7.62 During his evidence, Mr. Halpin told the Commission that Grace's mother's request was not routine and was more complex. He said that "*routine*" case included one where a person was looking for his or her own file, with no third party issues to be considered. In a complex case, Mr. Halpin said that the FOI researcher might have to consult with staff to obtain clarifications which might not always be apparent from the file, and he agreed that Mr. Smith's email to Mr. F. Walsh of 25th August, 2008, outlining the circumstances and complexities of the case and emphasising the need to meet with him, was an example of that. Mr. Halpin said that the researcher would have been "*seeking to understand what material would be relevant to the scope and if something was external to the scope they would then prepare the draft decision based on that.*"
- 7.63 Mr. Halpin said that the staff might offer a view on the request but would not be making a decision on it, adding that care would be taken to exclude them from any involvement as they were not the "*appropriate officer.*"

Mr. F. Walsh emails Ms Browne

- 7.64 On 26th August, 2008 Mr. F. Walsh emailed Ms Browne, copied to Mr. Smith and Mr. F. Walsh's superior, Ms Byrne. This was the day of one of the VAC meetings. He told Ms Browne that he had just spoken with Mr. Smith, who had given him an update on the case. He explained that he was not permitted to travel to view the files due to a "travel ban" (which restricted the ability to claim reimbursement of travel expenses).

Mr. F. Walsh told Ms Browne that he had asked Mr. Smith to send him on the files by post and that he would read them and discuss the matter with Ms Byrne. He concluded by saying that they would then return to Ms Browne and Mr. Smith and that they could decide how to progress from there.

- 7.65 Mr. F. Walsh did not recollect that correspondence at the Commission. Nor could he recall any conversation with Mr. Smith on 26th August, 2008 or what his “update” consisted of, beyond suggesting that Mr. Smith might have had some issues in relation to the release of records that he wanted to discuss with his own superior and that they wanted to see what was going to be released as part of the process. Mr. Smith was unable to assist the Commission with regard to that, as he did not recall receiving that email. However, as he was copied on it, he said that he would have read it *“for certain”*.

Mr. F. Walsh’s discussion with Ms Byrne – “a highly sensitive case”

- 7.66 At the Commission, Ms Byrne had no recollection of any conversations with Mr. F. Walsh in relation to Grace’s mother’s request.
- 7.67 Asked what he would have been discussing with his superior, Ms Byrne, Mr. F. Walsh said that he would defer to her in what he termed *“a highly sensitive case like this”*.
- 7.68 Mr. F. Walsh said that he would have expected to have received the files within a week of the request, though he also said that files would not necessarily all arrive together. The evidence to the Commission as to when files were received is considered below. He referred to the date of this email, 26th August, 2008, which was shortly before the expiry of the deadline when the records were due for release. He said that he did not know at that particular stage who held files in relation to Grace.
- 7.69 Bearing in mind Ms Browne’s evidence that a decision on releasing information on files had nothing to do with her, Mr. F. Walsh was asked why he referred to discussing the matter with Ms Byrne and then returning to Ms Browne and Mr. Smith. He said that he *“expected they would have expressed some concerns about the information being released to [Grace’s mother]”*. Mr. F. Walsh speculated that he and Ms Byrne would have considered this in terms of Grace’s mother’s rights to access the information and would have gone back to Ms Browne or Mr. Smith to inform them that they were *“obliged to release this because the Act provides for it”*. He could not say, however, that that was what occurred in this case.

- 7.70 Ms Browne told the Commission that she did not take anything from Mr. F. Walsh's email of 26th August. She said that she did not think that she or Mr. Smith had any function in decision-making on release of files but added that she and Mr. Smith would have been available to answer any questions Mr. F. Walsh and his superior might have had. She said that she did not know why he would have needed to speak to her after he had read the files.
- 7.71 Asked about the statement in his email that they could decide how to progress once he had returned to Ms Browne and Mr. Smith after discussing the matter with Ms Byrne, Mr. F. Walsh told the Commission that because the issue was "*so sensitive*", he would have deferred to Ms Byrne, his superior, and that she would have possibly "*run with the case*" at that stage in liaison with Mr. P. Walsh and Mr. Halpin. Mr. F. Walsh also suggested that he "*expected that they would have expressed some concerns about the information being released to [Grace's mother].*"
- 7.72 With regard to the basis for his view that the case was sensitive, Mr. F. Walsh said that it derived from whatever files he had read to that date and also that his view might have arisen from his communications with Ms Browne and Mr. Smith. However, he was unable to say whether he had, in fact, read any of Grace's files at that stage.
- 7.73 The Commission is satisfied that Mr. F. Walsh's view as to the sensitivity of the case in all likelihood arose from his communications with Ms Browne and his earlier discussion with Mr. Smith, reported above. The Commission is satisfied that Ms Browne's and Mr. Smith's contact at this time between with Mr. F. Walsh, underlined the particular degree of sensitivity and concern that prevailed with regard to the sharing of information in Grace's case. This, and the view that the sharing of information with Grace's mother might hamper her cooperation with the HSE, continued to be factors impacting the manner in which Grace's case was managed.

8. Expiration of statutory time limit for decision

- 8.1 Under s. 8(1) of the 1997 Act, a decision regarding a request was to be made not later than four weeks from the date of the receipt of the request.
- 8.2 On 1st September, 2008, four weeks following the receipt of Grace's mother's FOI request by the HSE, the statutory time limit for a decision to be made expired. There

was no notice given to Grace's mother, in contravention of s. 9 of the Act, that an extension of the statutory time period had been made.

- 8.3 As the standard letter of acknowledgment which issued to Grace's mother did not refer to the possibility of a deemed refusal, she was not on notice that a failure to make a decision on her request within the statutory timeframe constituted a refusal, in respect of which she could seek a review. Mr. F. Walsh could not recall any further communications with Grace's mother at this time.
- 8.4 Mr. P. Walsh told the Commission that, owing to significant other work pressures and reading himself into his new role as General Manager at the time, it did not cross his mind to follow up with Mr. F. Walsh in relation to Grace's mother's FOI request. As outlined previously, while Mr. P. Walsh believed that he probably had a role, as decision-maker, with regard to adherence to statutory time limits, he considered that the request was being processed by the Freedom of Information Unit until the time came for a decision to be made by him regarding the release of files.

Reasons why no decision within statutory deadline

- 8.5 The initial reason that the request had not been processed by the statutory deadline of 1st September, 2008 related to the delay in collecting or obtaining the documentation to be reviewed from the relevant sources.
- 8.6 In her evidence, Ms Byrne said that there were often considerable delays in releasing files under FOI and that this was fairly standard. She pointed out that the "*voluminous provision*" available in the Freedom of Information Act 2014 was not available back then and pointed out that a lot of cases took a very long time, with social work files to be processed, which entailed copying, scheduling and redacting them. She described it as a time-consuming process with no shortcuts. Ms Byrne said that the time limits contained in the Act were aspirational at best.
- 8.7 The Commission is satisfied that, in the early stages of the process, delays were not uncommon in the processing of FOI requests, and in the gathering in of documentation. The Commission is satisfied that the fact that a decision had not been made within the statutory time limit of four weeks, was not unreasonable in the circumstances.

Receipt of files by Mr. F. Walsh

- 8.8 The evidence on when Mr. F. Walsh received Grace's files from their various locations was not clear. It appears, however, that the files were received by him during September and October, 2008.
- 8.9 On 3rd September, 2008, Ms Browne emailed Mr. F. Walsh to say that she had sent the HSE files on Grace to him *via* the General Manager. She pointed out that there was also a file in one of their funded voluntary agencies where Grace attended day service (*i.e.* the local voluntary association), and asked if he also required a copy of that file.
- 8.10 On 4th September, 2008, Mr. F. Walsh responded to Ms Browne to confirm that all files had been requested and Ms Browne replied on 11th September, 2008 to say that Grace was in a day service in Day Service Provider A, which was run by the local voluntary association, and that she had asked the day service to forward its file directly to him.
- 8.11 Mr. F. Walsh then had a "*very vague*" recollection of Mr. P. Walsh's arriving in his office one day with files and telling him to come back to him (Mr. P. Walsh) when he was ready to release them. Mr. F. Walsh could not recall any discussion with Mr. P. Walsh on the matter, saying that he was "[l]iterally just dropping the files in".
- 8.12 Mr. F. Walsh could not recall when he went to Day Service Provider A to get its file on Grace, but suggested that it would have been soon after he received Ms Browne's email as he said that it would have been "*very remiss of me not to action it pretty soon.*"
- 8.13 Ms B's evidence was that Grace's full files and documents from Day Service Provider A, including her notes and Day Service Provider A's notes, had been requested by the HSE in July or August, 2008 and sent to the HSE for review. She did not know where the documents went after that.
- 8.14 Mr. F. Walsh said that he had only had a "*very vague*" recollection of looking at Grace's files. He could not say by what date he would have read them. He said that it was "*obviously very sensitive*" but added that his focus would have been on the release of records, not their contents as such. Explaining what he meant by describing it as a "*sensitive*" case, he pointed to the fact that it concerned a vulnerable adult who had spent many years in an "*informal care situation*" and that certain issues had come to light which prompted Grace's mother to submit a request for her records. Mr. F. Walsh

said that he was concerned for Grace, because it appeared that she had been neglected by the care services.

Steps following expiry of statutory time-limit

Concern that FOI request might hamper cooperation with Grace's mother

- 8.15 The state of concern about Grace's mother's FOI request at this time was further apparent in the email sent by Ms Browne to Mr. P. Walsh on 1st September, 2008. Events occurring within the HSE and the VAC in the management of Grace's case at this time, are reported in detail in Volume 1.
- 8.16 Reporting on a consultation that she had had with Mr. Farrell as to how they were to move forward in Grace's case, and, with respect to the FOI request, Ms Browne advised Mr. P. Walsh in the email that Mr. Farrell was "... *concerned that we keep contact with the biological mother as we need to ensure that we are working together in this regard. He is concerned that the FOI request and info revealed may hamper this.*"
- 8.17 Ms. Browne went on to note that "[t]he natural mother continues to have rights despite her lack of contact. However it is vital that we are 'on side'. Unfortunately the FOI request may hamper this. If the biological mother seeks to have the client removed from the 'carer', she would also need to have good reason."
- 8.18 Ms Browne said that she shared Mr. Farrell's view on working together with Grace's mother and keeping in contact with Grace. She told the Commission that she could not recall why he was concerned that cooperation with Grace's mother might be hampered by her freedom of information request and any information revealed on foot of it, but she thought that it was said at one stage that there was "*a concern that [Grace's mother] may withdraw her consent*" (as reported on at paragraph 5.4 of Chapter 6 of Volume 1, Ms Browne appeared to consider that such a reaction would have been counter-intuitive).
- 8.19 The Commission is satisfied that implicit in this was a recognition that Grace's mother's consent was obtained on the basis of only such information as the HSE chose to impart to her.

- 8.20 Mr. Farrell said that he was aware at that point of Grace's mother's freedom of information application and told the Commission that he would have thought at the time that it could "*impact on matters in dealings*" with her and that he could easily have said that to Ms Browne. He added that he gave no advice on how Grace's mother's freedom of information request should be handled.
- 8.21 Mr. Farrell also told the Commission that he was concerned that reputational damage to the HSE might be caused by information disclosed to Grace's mother on foot of her freedom of information request. Mr. Farrell recalled that he had told Ms Browne and Mr. Bergin at their meeting in March, 2008 that going to court was not without difficulty for the HSE, which he said was a reference to reputational damage. Mr. Farrell told the Commission that he could not say at that stage if the prospect of the HSE's being sued was in his mind.
- 8.22 Asked whether he recalled anybody mentioning to him the advice relayed by Ms Browne to Mr. P. Walsh following her conversation with Mr. Farrell, Mr. F. Walsh said that he did not.
- 8.23 Mr. F. Walsh's initial evidence to the Commission was that, following the expiry of the statutory deadline, Mr. P. Walsh was the "*key person*". He said that "*because the deadlines had passed unless I had been asked to review files from an FOI perspective that I hadn't been given or wasn't aware of, I would have passed the responsibility for it...back to the decision-maker.*" He said that, at that point, "*the matter would have rested between him and his supervisor and a group of staff that held the records as to what they were going to do next in terms of releasing the files*".
- 8.24 However, Mr. F. Walsh later clarified that the process of "*getting files out*" may have continued in his Unit after the expiry of the statutory time period and that Grace's mother's request could still have been worked on if he had not presented anything to Mr. P. Walsh on which the latter could make a decision. The Commission is satisfied that this is correct and is demonstrated in the evidence, below, of the Unit's ongoing role in processing the request. Mr. F. Walsh accepted that responsibility for dealing with Grace's mother in relation to the request remained with him following the expiry of the statutory time frame and before he had passed the files to Mr. P. Walsh, along with his recommendations, for Mr. P. Walsh's decision.

Counsel's opinion sought with respect to Grace's case

- 8.25 On 8th September, 2008, Mr. Farrell wrote to Mr. William Fitzgerald B.L seeking an opinion on the options available in Grace's case. With respect to Grace's mother's FOI request, Mr. Farrell advised that the HSE did not feel that Grace's mother would be of "*great assistance*" to it and that she had also sought certain information pursuant to FOI legislation, having been pointed in that direction by a social worker which, he opined, "*may or may not have been the right course of action.*" This matter is dealt with in greater detail in Chapter 9 of Volume 1.
- 8.26 Mr. Fitzgerald's opinion was sent to Mr. Farrell on 26th September, 2008. Mr. Farrell in turn forwarded it to Mr. P. Walsh on 2nd October, 2008.
- 8.27 Mr. P. Walsh was aware of Grace's mother's FOI request being "*live*" at this time. After reading Counsel's opinion and Mr. Smith's report, he said that his view of that request was that there was a process through the HSE's Consumer Affairs Department for dealing with such requests and that the files should be dealt with in accordance with both that and the governing legislation. While Mr. P. Walsh said that it was "*very concerning*", he said that he did not form any view other than that it needed to be processed under that legislation. He said that he could not say that he was concerned about any of the documents within the ambit of the request from the corporate perspective of the HSE.
- 8.28 Mr. P. Walsh also said that Grace's mother's "*renewed interest*" in the case, (referring to an earlier email of 22nd August, 2008 from him to Mr. Halpin, copied to Ms Browne, with regard to how to proceed in the case, reported upon in Chapter 6 of Volume 1) had nothing to do with the FOI request. He told the Commission that processing such requests was administered through the HSE's Consumer Affairs Department with reference to various pieces of legislation and that it was not something that he would necessarily have discretion over in terms of what issued to a requester. He pointed out that there was "*an objective reasoning based in the parameters of the legislation.*"
- 8.29 It is of note, however, that the above exchange of emails and the reference by Mr. P. Walsh in his email to Mr. Halpin, to "*the natural mothers [sic] renewed interest in the case*" coincided with a separate communication between Ms Browne, Mr. P. Walsh and Mr. Halpin at this time, specifically on the topic of Grace's mother's FOI letter of request (as reported at paragraph 7.48 above).

- 8.30 The Commission is satisfied that references to Grace's mother's "*renewed interest*" were inextricably tied up with the concern at this time about the provision of any information to Grace's mother while simultaneously, as reported in Part 1 of Volume 1, securing her consent as a supposed authority for the HSE to take particular actions in Grace's case.

VAC meeting of 29th September, 2008

- 8.31 Matters relating to this meeting, which concentrated in the main on issues relating to Grace's care, are more fully addressed in Chapter 9 of Volume 1. The report on aspects of the meeting specifically related to the FOI issue are now set out below.
- 8.32 Mr. Smith made his own note of this meeting, which contained some additional detail, including discussion of Ms Browne's recent contact with Grace's mother. His note recorded surprise on his part when Ms Browne mentioned that she had spoken again to Grace's mother. His note stated that Ms Browne had reassured her, in answer to a question from her, that there would be "*no shocks*" in her files.
- 8.33 Mr. Smith's note contained his analysis of the position. He drew a contrast between his writing to Grace's mother to emphasise Grace's vulnerability and Ms Browne's "*not informing [her] that [Grace] is at risk.*" He also queried in his analysis how much information Grace's mother was going to receive on foot of her FOI request and whether Ms Browne was "*truly representing*" his report to her.
- 8.34 Ms Browne took issue with this note in her evidence, saying that Mr. Smith's note was "*not accurate*" in that regard. Ms Browne said that she would have advised Grace's mother to "*get support [as] it might be upsetting.*" This was consistent with the content of her email to Mr. P. Walsh of 3rd September, 2008, reported on in Chapter 8 of Volume 1.
- 8.35 The Commission notes that Ms Browne's approach to Grace's mother was, in all likelihood, directed towards downplaying any concerns in order to ensure her continued cooperation and to avoid a withdrawal of her consent to the HSE to move Grace.

- 8.36 This was one of several matters that Ms Browne viewed as representing inaccuracies on Grace's file which, as referred to further below, she said were her only concerns in relation to the information released to Grace's mother under the FOI request.

Ms Browne's document entitled "*Re Clinical File - Vulnerable Adult 13/11/08*"

- 8.37 On 13th November, 2008, Ms Browne forwarded a note to Mr. P. Walsh and Mr. Maley. Among other matters, the note contained Ms Browne's comments in relation to certain entries made by Mr. Smith in Grace's file with which she took issue. She pointed out in her note that the pages in the file were numbered by the Freedom of Information Unit and that she had underlined entries in the file that she thought might not be appropriate in a clinical file. A number of differences of opinion between her interpretation of matters and that of Mr. Smith were apparent from this document.
- 8.38 It is evident from Ms Browne's note that work had begun on the FOI request by 13th November, 2008 in that, at a minimum, the pages of the copy of Grace's file had been numbered.

Mr. Maley speaks with Grace's mother

- 8.39 On 3rd December, 2008, Mr. Maley spoke to Grace's mother on the telephone. According to Mr. Maley's note of the call, Grace's mother told him that she had received no response to her FOI request to date.
- 8.40 In evidence, Mr. Maley thought it likely that Grace's mother had raised the issue of the FOI request herself. He did not recall how he responded to this, but he assumed that he told her that it took some time to finalise these things because he did not want to get into a discussion with her about it.
- 8.41 The Commission is satisfied from the evidence that Mr. Maley had no practical involvement with Grace's mother's FOI request.

9. Request for update

- 9.1 The month of February, 2009 saw increased communications within the HSE concerning the management of Grace's case and a particular focus upon whether the

HSE would proceed with a wardship application, as legally advised. These matters are reported in detail in Part 2 of Volume 1.

- 9.2 On 17th February, 2009, Ms Browne wrote to Mr. F. Walsh, copying her correspondence to Mr. P. Walsh, stating:

"I would appreciate if you could let me know if information/files have been released to [Grace's mother], mother of the above client.

We are currently working actively on this case, and need to know if info has been released."

- 9.3 Ms Browne said that she had subsequently contacted Mr. F. Walsh to ascertain the position and then emailed Ms Brennan stating that:

"...no final decision has been made yet with regard to the release of information. Any final decision will be channelled through Pat Walsh."

- 9.4 Ms Browne noted in her evidence that she appeared to be seeking to follow up with Mr. F. Walsh at this point but that she had no actual recollection of the emails or the conversation with him. She told the Commission that she would not have ordinarily followed up on FOI requests and noted that it might have been an action from the VAC, as evidenced by her responding to an email from Ms Brennan, the VAC's chairwoman.

- 9.5 Mr. F. Walsh recalled that the request was still with him in his office, though he did not recall specifically *"what was holding it up."* He said that the files must not have been ready for release at that point, but he did not know for certain what was happening with regard to the case between September, 2008 and February, 2009.

- 9.6 Mr. F. Walsh said that he could not recall any engagement with Mr. P. Walsh between October, 2008 and February, 2009. He said that it would not have been unusual for him to have engagement with a decision-maker with regard to practical matters to do with the request. He said that he could not recall whether he had ever spoken to a decision-maker about the substance of what the records showed, rather than as to whether it was a record amenable to release. However, speaking generally, he said that it could have happened.

- 9.7 Mr. F. Walsh gave further detail later in his evidence as to the process generally adopted. In this regard, he said:

"I would present the files to the decision-maker. They'd have the decision letter. They would have both the clean copy and the copy being released and there would be a schedule of records with it. The decision-maker will go through it. If they had any queries, they will come back and ask. If they were happy to release, they would sign the decision letter."

- 9.8 Mr. F. Walsh said that this could happen either by leaving the files with the decision-maker or going through any questions with the decision-maker over the telephone or in person.

- 9.9 The evidence to the Commission did not provide any real explanation for the failure to process the request within the Consumer Affairs Department between October, 2008 and February, 2009 when Ms Browne wrote to Mr. F. Walsh for an update. As reported above, Mr. F. Walsh acknowledged in his evidence that there was nothing outstanding from Grace's mother that he required before processing the request. This was an unexplained period of delay in the circumstances.

- 9.10 Also on 17th February, 2009, Mr. P. Walsh wrote to Ms Browne with regard to her concerns about *"contemporaneous notes by [Mr.] Smith on clients' files."* Mr. P. Walsh told Ms Browne that, having discussed the matter with the Freedom of Information Unit, he had been *"advised that the placement of contemporaneous notes etc. is appropriate and does form part of the record or file, in this regard the replacement of such notes and records by [Mr.] Smith is not inappropriate."* He advised that if Ms Browne was not in agreement with the content of such records, then she had *"a right to look to have these records amended to reflect what the correct position was"* to her recollection. Mr. P. Walsh recommended addressing the alleged *"inaccuracies"* with Mr. Smith directly to clarify the position or, if she preferred, to deal with the matter with him (Mr. P. Walsh), who would liaise with Mr. Smith on her behalf.

Telephone conversation between Mr. Farrell and Mr. P. Walsh - 26th February, 2009

- 9.11 On 26th February, 2009 Mr. Farrell spoke to Mr. P. Walsh on the telephone. Mr. Farrell made a note of what he described as a detailed discussion between himself and Mr.

P. Walsh in relation to Grace's case. This discussion is considered in detail in Part 2 of Volume 1 and, as reported there, it predominantly focused upon the risks for the HSE as a corporate body in taking a wardship application in Grace's case. Grace's mother's FOI request was also discussed, Mr. Farrell noting in his attendance that Mr. P. Walsh outlined that the FOI material had not yet been released to Grace's mother who, Mr. Farrell noted, did not want to "*become involved in the process*" and was residing abroad.

9.12 Mr. Farrell told the Commission that he had no other knowledge of the FOI request.

9.13 While Mr. P. Walsh said that he could not remember having had any conversation with Mr. Farrell about the FOI request, he fully accepted on reviewing Mr. Farrell's attendance that it was possible that they did have such a discussion and the Commission is satisfied that this is the case.

Mr. Smith writes to Mr. P. Walsh

9.14 On 22nd April, 2009, Mr. Smith wrote to Mr. P. Walsh in relation to Grace's case and provided a general update on his draft social work report from March, 2008 (reported upon in Part 2 of Volume 1). In relation to Grace's mother's FOI request, Mr. Smith wrote:

"She has been informed that [Grace] is a vulnerable adult but has not been informed that there are specific concerns about the placement. She has requested the files under the Freedom of Information Act but has not proceeded further with this."

9.15 Mr. P. Walsh recalled receiving this letter and said that he was already aware of its contents.

Mr. P. Walsh writes to Mr. Farrell - 14th May, 2009

9.16 On 14th May, 2009, Mr. P. Walsh wrote to Mr. Farrell, referring to previous conversations and correspondence and synopsising Mr. Smith's letter of 22nd April, 2009. In his letter, Mr. P. Walsh sought updated legal advice from Senior Counsel in relation to the HSE's position in Grace's case. The full extent of the communication with Mr. Farrell and within the HSE, is reported in detail in Part 2 of Volume 1.

- 9.17 Of relevance to this Volume, Mr. P. Walsh referred to the fact that Grace's mother had requested files under the Freedom of Information Act which, he stated, were being prepared for release, and pointed out to Mr. Farrell that she "*was [not] aware at this point of specific concerns*"²

Mr. Smith speaks to Grace's mother

- 9.18 The circumstances whereby Ms Browne asked Mr. Smith to make contact with Grace's mother at this stage are set out in Part 2 of Volume 1. On 1st July, 2009 Mr. Smith spoke to Grace's mother in relation to Grace's case. Mr. Smith recorded that she confirmed to him that she had submitted her FOI request but had not yet heard anything back from the HSE about it.
- 9.19 Mr. Smith told the Commission that he had been surprised at how "*engaged*" Grace's mother was at this point in time. This, he said, was in context of Ms Browne's having given him the impression that Grace's mother had not followed up on her FOI request.

Ms B's involvement in Grace's mother's FOI request

- 9.20 The next communication with Grace's mother with respect to the FOI request was in August, 2009 after Grace had been moved from her placement with Mrs. X. On 27th August, 2009 Ms B spoke to Grace's mother on the telephone. Grace's mother had not heard back from the HSE in relation to her FOI request. Ms B told Grace's mother that she would seek out the appropriate contact details in relation to this and send them to her.
- 9.21 After speaking with Grace's mother, Ms B contacted Mr. F. Walsh. She recalled that when she asked him about Grace's mother's request, he was able to recall it and its status immediately. Ms B said that Mr. F. Walsh proceeded on the basis that she had authority to speak on Grace's mother's behalf and that he did not raise any issue in this regard. She described Mr. F. Walsh as very helpful to deal with in general.
- 9.22 On 4th September, 2009, Ms B again spoke with Grace's mother and, relaying her conversation with Mr. F. Walsh, she told her that she had spoken with him and that he had told her that he had written to her (Grace's mother) twice but, upon hearing nothing

² it was apparent from the evidence of Mr. P. Walsh and Mr. Farrell that the word "most" was a typographical error and that it should instead have read "not".

back, had not processed her request. Ms B noted that Mr. F. Walsh would now be proceeding to process the request.

The issue of correspondence

- 9.23 There was no documentary record of the two letters which Ms B recorded Mr. F. Walsh as having sent to Grace's mother in the records disclosed by either the HSE or Grace's mother to the Commission. As reported at paragraph 9.29 below, Grace's mother told Ms B that she had never received such letters. Mr. F. Walsh had no recollection of sending the letters and could not say what they had contained, but he observed that *"if I said that I had written two letters then they should exist"*. Mr. F. Walsh could not say why, when speaking with Ms Browne on 17th February, 2009 in relation to the FOI request, he had not said that any delay in processing the request was on account of his awaiting some reply from Grace's mother. As reported at paragraph 9.5 above, Mr. F. Walsh could not recall specifically what was holding up the process at that stage.
- 9.24 In her evidence, Ms Byrne said that there were standard steps required by a decision-maker to satisfy themselves as to the identity of the FOI requester. Ms Byrne said that the practice, in general terms, would be not to follow up on the processing of files until such clarification had been obtained. She said that she thought that it was likely that their Unit would thus have sought clarification from Grace's mother as to her identity but was not in a position to say whether or not that had actually happened in this particular case; there was no evidence of this from the records provided by the HSE to the Commission.
- 9.25 On the question of whether Grace's mother had been written to after the acknowledgement of her request, two possibilities were suggested to Mr. F. Walsh: the first was that he had not sent any further letters to Grace's mother after the letter of acknowledgement; the second was that if he had done so, he was not awaiting any information that delayed him in processing the FOI request. Mr. F. Walsh agreed that these were the two possibilities.
- 9.26 The Commission is satisfied that, when she spoke with Mr. F. Walsh as reported at paragraph 9.21 above, Ms B was not required to give anything on behalf of Grace's mother in order for the processing of the request to proceed.

- 9.27 If any letters were sent to Grace's mother (a fact that cannot be established on the evidence) the Commission is not satisfied on the evidence that the reason for delay in dealing with Grace's mother's FOI request over the period up to August / September, 2009 was attributable to a response to any enquiry made to Grace's mother's being awaited. After Mr. F. Walsh spoke to Ms B, he recommenced processing the request, as reported below.
- 9.28 In circumstances where the Commission had no evidence that there was any outstanding information awaited from Grace's mother before the FOI request could be progressed, it is satisfied that this amounted to a failure by the HSE and the Freedom of Information Unit properly to address the request by this stage.

Progressing the request

- 9.29 Ms B spoke to Mr. F. Walsh on 25th September, 2009 after speaking with Grace's mother, who had still not heard anything from the Freedom of Information Unit. Ms B told the Commission that she had told Grace's mother what Mr. F. Walsh had said in relation to Grace's mother's not responding to the letters that he had sent her and that, in response, Grace's mother told her that she had never received the letters in question.
- 9.30 Mr. F. Walsh reported concerns to her regarding releasing the files directly to Grace's mother and he queried whether the files could be released to Ms B on her behalf. Ms B thereafter confirmed with Grace's mother that she would be happy for the files to be released to Ms B on her behalf.
- 9.31 Mr. P. Walsh was not aware of this conversation between Mr. F. Walsh and Ms B and he did not believe that he was aware of Mr. F. Walsh's concerns about releasing files directly to Grace's mother. Mr. P. Walsh said that he would have had regular contact with both Mr. F. Walsh and Ms Byrne in the course of his work; however, he could not say whether or not he had any contact with them or Ms Browne in relation to Grace's case, between February and September, 2009.
- 9.32 Mr. P. Walsh's involvement in the management of Grace's case over that period, including on the issue of the HSE's communications with Grace's mother, is reported in detail in Volume 1.

- 9.33 Mr. F. Walsh recalled speaking with Ms B about giving her the files and he said that he viewed the files as “*quite sensitive*” and that they could be “*quite distressing*”. He said that he had gleaned this from his own reading of the files by that stage. He said that they would “*link*” with a social worker in order to support the recipient in going through the files and agreed that the fact that Grace’s mother lived in another jurisdiction was a complicating factor. Mr. F. Walsh said that it would be better if the recipient of files like these had someone supportive there with them. He said that, ultimately, this would be a matter for the decision-maker from a “*compassionate perspective*.”
- 9.34 On 28th September, 2009, Ms B again spoke with Mr. F. Walsh who advised her that “*files will be another couple of w[ee]ks.*” She said that the purpose of the call was because she was due to book a flight to visit Grace’s mother in England and wanted to bring the files over with her.
- 9.35 On 2nd October, 2009, Ms B emailed Mr. F. Walsh to check whether there had been an update in relation to the request. Mr. F. Walsh responded, advising that “*I think it will take me about another two weeks to get the files finished.*” Release of files was normally by registered post; however, in cases where an individual was vulnerable, alternative arrangements could be put in place to view the records. Ms B replied to Mr. F. Walsh to say that Grace’s mother would like her to travel over with the files and provide her with support.
- 9.36 In his evidence, Mr. F. Walsh could not explain why it was going to be another two weeks to get the files finished. At this stage it was approximately one year after the expiration of the statutory deadline for release of the files. Although he could recall the issue of the “*sensitivity*” of the files, Mr. F. Walsh had little other recollection of Grace’s case over this time period without the aid of documentation circulated for the hearings.
- 9.37 On 16th October, 2009 Ms B updated Grace’s mother that the decision on the FOI request was not due for another two weeks. Ms B noted that Grace’s mother was going to provide consent in writing for the file to be released to Ms B.
- 9.38 On 29th October, 2009, Mr. F. Walsh telephoned Ms B and advised her that the release of the documents was delayed and would take approximately another three weeks. Ms B said that she would contact him at that stage.

- 9.39 Ms B told the Commission that it was her impression that the delay was due to the volume of files that required preparation. Ms B, at that time, assumed that there were “*voluminous files*” that had to be gone through to apply redactions and exceptions under the Act. Ms B observed, however, that what was actually released to Grace’s mother in the end was very little documentation.
- 9.40 Mr. F. Walsh did not recall this telephone conversation with Ms B or the reason why the files were being delayed for a further three weeks. He noted in this regard that he was disappointed that he could not enlighten the Commission as to the delay in the processing of files for release. There was no note made of the reason for this further delay. Asked whether it was his practice, where delays such as this occurred, to make notes detailing the reasons for such delay, Mr. F. Walsh said that it should have been his practice and suggested that, in the ordinary course, he would have done so.
- 9.41 On 30th November, 2009, Ms B telephoned Mr. F. Walsh who told her that he would be working on the request that day and would have it finished soon. Ms B recorded in a note of their call that “*the process is then that it will go to Pat Walsh, HSE General Manager for approval. Fergal [Walsh] stated that 99% of the time, this is a formality and it is signed off by the General Manager, but he can’t say for sure as he doesn’t know ‘what else might be going on?’*”
- 9.42 While he had no memory of the call, Mr. F. Walsh agreed that “*it sounds absolutely most likely that’s what did happen if [Ms B] has it written down, absolutely.*”
- 9.43 With regard to Ms B’s record of his reference to “*what else might be going on*”, Mr. F. Walsh said that there might have been issues around that particular case that would have been the responsibility of Mr. P. Walsh to deal with. He could not recall their conversation, but said that “*if there were issues around the receipt of legal advice about the release of records or about a particular case, you know because things are dealt with at different levels within the organisation; [Mr. P. Walsh] as a senior manager would have been dealing with issues that I may not have been aware of...and wouldn’t need to be aware of in relation to this particular case.*”
- 9.44 While Mr. F. Walsh said that there were “*definitely other concerns that [Mr. P. Walsh] would have had that wouldn’t have necessarily come into my radar*”, he said he was not aware from his reading of the files of any issues other than “*the broader responsibility that [Mr. P. Walsh] would have had in relation to this individual as the*

[General Manager].” Mr. F. Walsh was aware, however, of the special interest that had been taken by HSE management in the making of the FOI request by Grace’s mother in this case.

- 9.45 Referring to this telephone call, Ms B said that it was certainly accepted between the two of them that these were “*very, very sensitive files*” and that the release to Grace’s mother was “*going to cause controversy or difficulty*”. She said that, because of what she perceived to be a mutual understanding at the time, she did not enquire more as to what Mr. F. Walsh had meant by “*what else might be going on*”. She took it to relate to the complexity and sensitivity of the case, noting that Mr. F. Walsh would have read Grace’s file. She took it that his knowledge of the issues arising in the case would have been greater than her own.
- 9.46 In his evidence, Mr. P. Walsh disagreed with Mr. F. Walsh’s statement in relation to “99 per cent” of cases requiring an effective “*rubber stamping*” but accepted that in the majority of cases he would have agreed with the view put forward by a research officer with regard to the release of files. He told the Commission that, generally, if any intervention was made by him, it would be for the purpose of clarification.
- 9.47 The next contact between Ms B and Mr. F. Walsh was on 12th December, 2009 when he told her that he had passed the matter to his manager, Ms Byrne, and that the release of the files depended on what management decided. Her note recorded that he told her that the files would “*probably not [be] released before Xmas and can’t say for definite*”.
- 9.48 Ms B’s understanding from this call was that Mr. F. Walsh had finished his task with regard to the processing of the FOI request and that it had been passed to his manager for a decision about what to release based on his recommendations. There was no conversation between herself and Mr. F. Walsh as regards to why the files were going to Mr. F. Walsh’s manager at this stage.
- 9.49 Mr. F. Walsh did not remember this conversation with Ms B or why he was proposing to pass the file to his manager, Ms Byrne. His evidence was that in the ordinary course, a file would not be passed to his manager unless he had queries about particular issues. Speaking in general, he said that it could relate to queries about what could or could not be released under the legislation or if he had a doubt. Mr. F. Walsh said that

the sensitivity of the case would not normally be a reason for him to consult his manager.

- 9.50 Ms Byrne said that she had no recollection of having any conversation with Mr. F. Walsh about Grace's mother's FOI request in December, 2009. She pointed out that, generally speaking, she would have discussed backgrounds of cases fairly often, and that they dealt with hundreds of cases per year, some of which cases were very complex. Ms Byrne told the Commission that they would have had fairly regular team meetings to discuss cases and the approach to these more than anything else. She said that the research officers read the detail and did a line-by-line review of documents. She said that often they would discuss: *"...is access appropriate? What is the context and background of the case?"* Ms Byrne said that where there were specific technical FOI issues, she would be asked for advice because that was her job as the FOI expert.
- 9.51 Ms Byrne observed that a confusing factor with regard to giving evidence on Grace's mother's FOI request was the fact that there were subsequent FOI requests made in later years and that she found it hard to distinguish between the various requests. She said that while she knew Grace's case *"very well"*, she did not remember or distinguish this particular FOI request. Ms Byrne also said that responsibility for a case would not pass from the research officer, Mr. F. Walsh, to her, but that if a research officer came to her for assistance she would give it. She said that this was a common occurrence.
- 9.52 On 15th December, 2009 Ms B telephoned Ms Byrne, seeking an update on the status of the request. Her note recorded that Ms Byrne would call her back.
- 9.53 On the same day, 15th December, 2009, Mr. P. Walsh emailed Ms Browne, Mr. John Martin, who was the Child Care Manager in Waterford Community Services, Mr. Maley and Mr. Halpin. He advised them that *"I have just had a phone call from Fergal Walsh in the F.O.I. office, and he has advised me that he has the f.o.i. request ready for release etc."* He said in the email that Mr. F. Walsh also advised him that Ms B had been making contact to enquire about release of files and that Grace's mother had given written permission for the files to be released to Ms B rather than being sent directly to her. Mr. P. Walsh set out that *"I am due on leave tomorrow, [Wednesday], but have arranged to call to [Mr. F. Walsh]'s office to review the file. I will not be making [a decision] around releasing / or not tomorrow, but will get some feel for what [Ms B] has been asking."*

- 9.54 It was not clear from the evidence as to whether Mr. P. Walsh did call to Mr. F. Walsh at that stage, as neither could recall whether that had occurred at this time.

Delay between September, 2009 and December, 2009

Finding

- 9.55 Neither Mr. F. Walsh (nor anybody else) had any explanation regarding the delay in completing his work in respect of Grace's mother's freedom of information request. Postponements and further delay of the release of documentation occurred without clear explanation as to the reason for the delay in progressing and completing the processing of the request over the above period.
- 9.56 The Commission finds that there were no proper explanations in the evidence for the delay in completing the processing of the FOI request by Mr. F. Walsh / the FOI Office between September and mid-December, 2009. The Commission is not satisfied that the delay was attributable to the volume of material involved, as the files under consideration were by no means voluminous. It appears, however, that in carrying out his work, Mr. F. Walsh was particularly mindful of the sensitivity of the case within the HSE, and that this was a case which he was passing to Ms Byrne as his manager. By the time Mr. F. Walsh advised Mr. P. Walsh on 15th December, 2009 that the files pertaining to the FOI request were ready for release, over 14 months had elapsed since the original request.

Ms B as proposed recipient of the FOI material

- 9.57 Mr. P. Walsh was aware on 15th December, 2009 of the suggestion that Ms B might receive the files on Grace's mother's behalf. He told the Commission that he was generally aware that where people needed support, files could be "*arranged*" through a third party. He said that it would not have been terribly unusual that people would have been supported in this way. Mr. P. Walsh said that they would "*expect*" that Mr. F. Walsh was focusing on the "*sensitive nature of the files and the content of the files and that it may be upsetting for [Grace's mother]*" and that he saw the merits in this approach.
- 9.58 On 16th December, 2009 Ms B telephoned Ms Byrne and queried the delay in determining Grace's mother's FOI request. Ms Byrne told her that Mr. P. Walsh was on leave and that he would have to make a decision in January, 2010.

- 9.59 In her evidence, Ms B said that *“this is where the frustration started”* for her. It was her understanding that the files were ready for release at this point and she said that she was *“put out”* by the fact that one year and four months after a statutory deadline had passed, the matter was being delayed further due to the fact that someone was on annual leave. Remarking that *“the Act does not say 28 days unless somebody is on annual leave in which case the delay can be indefinite.”* Ms B said that, at this stage, she felt she was getting nowhere.
- 9.60 Mr. P. Walsh said that, by this point, he was yet to receive Mr. F. Walsh’s recommendations in relation to the release of the files. However, as noted above, he had been told by Mr. F. Walsh that the files were ready for release and, in accordance with his email of 15th December, 2009 to Ms Browne, Mr. Martin, Mr. Maley, and Mr. Halpin about Grace’s case, he was going to review them, although he was not going to make a decision on them at that stage, but wanted to *“get some feel for what [Ms B] has been asking.”*
- 9.61 On 22nd December, 2009, Ms Browne replied to Mr. P. Walsh’s email, noting that it seemed strange that a file requested under FOI would be released to someone other than the applicant and that she did not understand how Ms B had got involved.
- 9.62 Ms Browne did not recall sending this email and said that she had no involvement in relation to Grace’s mother’s FOI request between her correspondence with Mr. F. Walsh in February, 2009 and this email. She told the Commission that she had no state of knowledge as regards the progress of the request. She said that her statement in relation to Ms B’s involvement was just a comment and that had she known at that point the degree to which Ms B was involved with Grace’s mother, she would probably not have made it. Without that knowledge at the time, she said that she thought that Ms B’s involvement was unusual.
- 9.63 This issue of Ms B’s involvement with Grace’s mother’s FOI request was considered further at a HSE meeting convened in January, 2010, as reported below.
- 9.64 On 7th January, 2010 a teleconference took place in Grace’s case between Mr. P. Walsh, Ms Browne, Mr. Maley and Mr. Martin. Of relevance to this Volume, the minutes of the conference noted: *“what information can we responsibly give [Grace’s mother]?”* Mr. Maley was also noted to have queried whether the information to be released should go out to a third party, *i.e.* the local voluntary association. Mr. P. Walsh was

noted to have stated that it was not normal practice and that the file should go directly to the applicant in this case.

- 9.65 Mr. P. Walsh told the Commission that the reference to what information the HSE could “responsibly” give to Grace’s mother related, he believed, to the “*unsubstantiated allegations that were contained in Mr. Smith’s report.*” He later accepted that it was a “reasonable assertion” that this discussion must have related to the information to be given to Grace’s mother in response to her FOI request, as that was what was under discussion. He had no recollection of the conversation insofar as it related to Grace’s mother’s FOI request going to a third party.
- 9.66 On 7th January, 2010, following the teleconference, Ms Browne emailed Mr. Martin, Mr. P. Walsh and Mr. Maley saying she was relieved that the files would be made available directly to Grace’s mother. She indicated that it was only recently that Ms B had come into the picture and that she was not sure how the suggestion was made that she be sent the files for Grace’s mother. Ms Browne noted that, in her experience, it had never happened before.
- 9.67 Also on 7th January, 2010, Mr. P. Walsh emailed Mr. Martin, Ms Browne and Mr. Maley stating that the request to have the FOI response issued to a third party was unusual except when issuing to a legal representative. He noted that the decision as to where it was issued rested with him as decision-maker and he confirmed that he would be issuing it to Grace’s mother directly. He also noted that this was not for circulation to the “*wider community*” at that point.
- 9.68 Asked why, having accepted that he saw the merits in Mr. F. Walsh’s approach in December, 2009 that the files be sent through Ms B, he had now decided to send them directly to Grace’s mother, Mr. P. Walsh said that the reason for this was because he felt that “*there was information in the files from my limited knowledge of the files, that was very personal to [Grace’s mother] and I don’t know, I suppose, where my mind was, if she were aware of the particular sensitive issues in the file, would she be happy – would [Grace’s mother] rather be happy to have them released to a third party.*” He did not communicate this concern to Ms B or Grace’s mother at the time. Mr. P. Walsh had not, at this point, received the files for proposed release from Mr. F. Walsh. However, from his involvement in Grace’s case, as reported in Volume 1, he had a level of knowledge of the type of information on the file.

- 9.69 The Commission is satisfied that although Mr. P. Walsh had not seen the files at this stage, he was nonetheless very aware of the issues surrounding Grace's case and was familiar with Mr. Smith's draft report which essentially highlighted the issues as Mr. Smith saw them. Mr. P. Walsh was aware of the risk of exposure for the HSE of its and the SEHB's mismanagement of Grace's case during her time in the Family X placement, as reported in Parts 1 and 2 of Volume 1.
- 9.70 The Commission is not satisfied that the concern about the release of the files to Ms B at this time was, in fact, based on a belief that Grace's mother would not be happy to have any of her personal information released to Ms B. The emails of 22nd December, 2009 to 7th January, 2010, reported upon above, set out the reasoning and rationale for releasing the files to Ms B and the local voluntary association and did not refer to any concerns about what Grace's mother might want. The notes of the teleconference, above, did not disclose any apprehension on the part of the attendees that Grace's mother would not want personal information to be viewed by Ms B. There was no contemporaneous evidence to the Commission to suggest that there was any basis for this concern.

Grace's mother seeks more information

- 9.71 On 11th January, 2010 Ms B spoke to Grace's mother who queried the status of her FOI request.
- 9.72 Ms B said the frustration at this stage was that Grace's mother had a lot of questions with regard to Grace to which, in Ms B's view, she was entitled to answers, under a FOI request or otherwise. These questions arose from what she had been told by Mr. Smith, in particular that Grace had had injuries. In this regard, Ms B pointed out that it was Mr. Smith of the HSE who had recommended that Grace's mother pursue the request and said that the delays were causing Grace's mother a lot of anxiety and difficulty. Ms B said that, at this stage in January, 2010, she had no explanation to offer Grace's mother about the delay.
- 9.73 On 13th January, 2010, Ms B wrote to Mr. Smith. She outlined that she was writing to him on Grace's mother's behalf as a result of the upset and distress that the lack of information in relation to her daughter had caused her. Ms B stated that Grace's mother had requested that she write to Mr. Smith detailing questions that she would like him to answer in relation to Grace and her placement. She said that she had provided

Grace's mother with information that was available to her already and that Grace's mother would appreciate a written response from Mr. Smith, followed up by a telephone call to discuss matters further. Ms B stated that she believed that this process would prepare Grace's mother for the information that she would subsequently receive through a response to her FOI request and she outlined a series of questions for Mr. Smith.

- 9.74 In her evidence, Ms B said that the reason for this letter was that she believed there was no good reason, whether Grace's mother had made a FOI request or not, why she was not entitled to or should not have the information she sought in relation to her daughter. She said that she felt that it would be preferable if the information were given to Grace's mother by a social worker in writing in an appropriate manner, as opposed to getting what would effectively be raw information.
- 9.75 Mr. P. Walsh said that he was not aware of this letter at the time. Ms Browne could not recall whether or not she was made aware of it.

Ms Browne's concerns regarding file material

- 9.76 On 13th January, 2010, Ms Browne wrote to Mr. P. Walsh as she believed that there were certain inaccuracies in Grace's file and she wanted to make a record of her view of those inaccuracies. She indicated that this was particularly pertinent given that the file was due to be released under the Freedom of Information Act. Ms Browne therefore wanted to add her comments to the record prior to the release of the file.
- 9.77 Ms Browne highlighted the entries which she believed did not represent the situation clearly within Grace's file and noted that she wished to clarify the position. Some of Ms Browne's concerns related to files and documentation that were created after Grace's mother had submitted her FOI request. Mr. P. Walsh had previously written to her on this topic in February, 2009 as reported in paragraph 9.10 above.
- 9.78 Ms Browne said that while she could not specifically recall sending this letter, she recalled the issue very well, given that it was something about which she was upset and felt very, very strongly about. She said it took up a lot of thought and that it was a long-standing issue for her. Ms Browne said that she did not know what action was possible in terms of the file but she wanted the "*inaccuracies*" on file to be recorded. She could not recall her discussion with Mr. P. Walsh with regard to this letter. She

said that, as far as she was aware, no action was ever taken on foot of this interaction with Mr. P. Walsh with regard to Grace's file.

- 9.79 Mr. P. Walsh said that he sought advice from the Consumer Affairs Department in relation to the concerns Ms Browne was raising and whether *"in fact there was anything being released – to which these would have been pertinent and how that might be managed."* Mr. P. Walsh believed that he was aware at the time that a request for information made under the 1997 Act was *"date stamped"* upon receipt and he thought that the request was limited under the Act to what was on the file when the request was received. Ms Browne was not aware of this when she raised her concerns with Mr. P. Walsh. The relevant legislation was silent on this question.
- 9.80 The consequence of the position outlined by Mr. P. Walsh was that, of the documents with which Ms Browne had an issue, Grace's mother's FOI request applied to only three of them. They were not released under FOI on the stated basis that two of them involved functions and negotiations of a public body and the third contained personal information in relation to another individual. Mr. P. Walsh accepted in his evidence that, had he looked at the schedule of documents to be released in detail in January, 2010, he would have known before meeting with Mr. F. Walsh, Ms Browne and Ms Byrne (reported upon below) that none of the allegedly inaccurate documents which were of concern to Ms Browne were listed to be released to Grace's mother. However, he said that if he had looked at the schedules of documents to be released for files 1 and 2 at that stage, he did not believe that he would have gone into that level of detail.

Communication between Ms B and Grace's mother

- 9.81 On 14th January, 2010 Ms B wrote to Grace's mother and told her that she had been speaking with Mr. F. Walsh regularly in relation to her FOI request who told her that the files would be given to Mr. P. Walsh by 15th January, 2010.
- 9.82 On 22nd January, 2010 Ms B noted a telephone conversation with Grace's mother to tell her that she would write a letter to Mr. P. Walsh regarding the release of files and that Grace's mother was satisfied with this. Ms B told her that Mr. Smith wished to meet with her, and she noted that Grace's mother said that she would consider how she would come to Ireland and that she would still like Ms B to go through the files with her.

Ms B seeks further update

- 9.83 On 3rd February, 2010, Ms B sent an email to Mr. P. Walsh requesting an update regarding the release of FOI files.
- 9.84 On 12th February, 2010, Ms B spoke with Mr. F. Walsh. He told her that Grace's mother's request was delayed further, and Ms B queried this. Mr. F. Walsh noted in response that the request had been made in July, 2008 and that he had received files shortly afterwards. He repeated that he had written to Grace's mother twice but, having received no response, had set the files aside. Mr. F. Walsh told Ms B that progress on the case began again following her contact with him on Grace's mother's behalf in August, 2009. Ms B's note recorded that Mr. F. Walsh had told her that the delay would now be approximately a further four weeks and that he also told her that there had been another delay. He suggested that Ms B contact Mr. P. Walsh and Ms Byrne.
- 9.85 Mr. F. Walsh could not recall this conversation with Ms B, nor could he throw any further light on the reason for the ongoing delay of the HSE in the release of documentation on foot of Grace's mother's FOI request.
- 9.86 In her evidence, Ms Byrne said that Mr. F. Walsh's suggestion that Ms B email Mr. P. Walsh and herself, he was attempting to "*flag it up to*" her. She noted that, if there were delays, which were not uncommon, and that if somebody wanted to make a complaint or have the issue raised with somebody more senior, then it was to her that Mr. F. Walsh would go.
- 9.87 Mr. P. Walsh told the Commission that he did not believe that he was aware, at that point in time, that Mr. F. Walsh's explanation to Ms B for the reason for the delay in the release of files was that he had written to Grace's mother on two occasions without reply. Mr. P. Walsh reiterated that communication between the Freedom of Information Unit and "*the requester*" would happen in the background. At this stage, however, the files were ready for release to Mr. P. Walsh and progress of the request and the decision on the documents to be released were in his hands.
- 9.88 Ms B also telephoned Grace's mother on 18th February, 2010, regarding a proposed meeting with Mr. Smith to have some questions answered. She recorded that Grace's mother might travel to Ireland in June, 2010 to sort out some things in relation to Grace.
- 9.89 On 26th February, 2010, Ms B again telephoned Grace's mother to ask whether she would like to make a complaint regarding delay in addressing her FOI request as there

had been no response yet from Mr. P. Walsh. Grace's mother confirmed that she would as, Ms B noted, she was finding the failure to release the files along with the lack of communication / uncertainty very stressful. Ms B agreed to write the complaint letter.

9.90 On 2nd March, 2010, Ms B forwarded two copies of the draft letter of complaint to Grace's mother, one for her to keep and the other to send to Mr. Halpin. The draft was addressed to Mr. Halpin on the basis that he was Mr. P. Walsh's superior.

9.91 On 15th March, 2010, Grace's mother sent the letter of complaint to Mr. Halpin as follows:

"Dear Mr. Halpin,

I am writing to make a complaint in relation to a Freedom of Information request I made in July 2008 in respect of my daughter [Grace], DOB [redacted]. I am yet to receive these files under the provisions of the Freedom of Information Act, 1997.

My daughter's social worker, [Ms B], was in contact with FOI officer Mr Fergal Walsh on my behalf on a number of occasions from August 2009 until January 2010. I am therefore aware that the files were completed in January 2010 and are awaiting approval for release by Mr Pat Walsh, A/General Manager, HSE, Cork Rd. Waterford.

Despite [Ms B] requesting that Mr Pat Walsh contact me to notify me of a date for release of these files, I have not yet had any contact.

I understand that the statutory timeframe for release of information under the Freedom of Information Act is 28 days; I have been waiting for almost 20 months and I have had no notification re: timescale for release nor have I been notified of the reason for the delay.

Due to the immense distress this has cause me, I now feel that I have no option other than to make a complaint in writing in relation to how my Freedom of Information request has been delayed, and the lack of communication re: same.

I shall await a response to this complaint within the statutory timeframes.”

- 9.92 Mr. Halpin’s role in relation to the FOI request was to address any internal review that might have arisen in relation to it. He did not recall enquiring into the status of this particular FOI request. He said that while he might be aware of a number of requests in the system, he would not become involved in them due to the nature of his role.
- 9.93 Asked about delay, Mr. Halpin said that, if he had reflected upon it, he would have been concerned about it.
- 9.94 Mr. Halpin sent an acknowledgement of receipt of this letter to Grace’s mother on 25th March, 2010.
- 9.95 Ms B said that the purpose of a written complaint within the HSE was to elevate it to a *“stage two complaint which requires a particular response, you know, a formal response, which requires the appointment of a complaints officer, somebody to investigate an issue or a report arising out of that.”* A “stage two” complaint was to receive an acknowledgement within five working days with an investigation and response coming within 20 working days. If no decision had been made, a response indicating another deadline of 30 days was due and if that deadline was not met, it was open to the complainant to report it to the Ombudsman (who dealt with complaints against public service providers).
- 9.96 Mr. Halpin did not recall receiving this complaint and could not recall his actions in relation to it. He said, however, that he would have first acknowledged the letter before having the matter *“checked out”* in terms of the position. Mr. Halpin suggested that as this complaint related to a delay in issuing a decision, the remedy for the complaint was for the decision to be made and he said that his method of following up the complaint was to ensure that this happened. He noted that this had happened *“six or seven weeks later.”* In this regard, Mr. Halpin’s evidence was to the effect that he did not consider that a detailed response or letter to Grace’s mother in relation to her complaint was an obligation of his, due to the fact that her complaint was, in his view, resolved.
- 9.97 Mr. Halpin took the approach that the purpose of the complaint was to elicit action on the part of the HSE, rather than to account for the delay that had occurred in doing so.

The resolution as described by Mr. Halpin above, therefore, did not address the purpose of the complaint or account for the delay and was not a full and appropriate response to the complaint that was made.

- 9.98 Mr. P. Walsh was unsure as to whether the complaint had been brought to his attention. He said that it might well have been, and assumed that it would have been brought to his attention by Mr. Halpin's office shortly after it was received. However, he could not recall discussion in relation to it. He said that, at the time, he was trying to arrange a time to go through Mr. F. Walsh's advice. Mr. P. Walsh explained that much of his weekly working time, at that point in 2010, was focused on cost containment issues and pressures in the whole working environment.
- 9.99 Mr. F. Walsh could not recall this letter and could not recall being contacted about the complaint. There was no evidence to the Commission that he had been.
- 9.100 Ms Byrne could not recall the complaint about delay ever being brought to her attention by Mr. Halpin. She said that complaints in relation to a delay in the processing of a FOI request that came under her remit might have been brought to her attention, but she could not recall this specifically. There was no evidence to suggest that it had been brought to her attention.
- 9.101 There was no evidence to the Commission of any enquiry having been made within the HSE, for the purpose of answering the complaint, as to the reason for a delay of this length. The Commission is satisfied, on the evidence, that that aspect was effectively ignored.
- 9.102 In his evidence, Mr. F. Walsh fully accepted that a delay of 20 months in the release of information under a FOI request was worthy of "*serious complaint*". He said that this period of delay was not normal and that they "*were generally pretty good*" on timeframes, with voluminous files being processed within about two months. He said that this was a "*particularly difficult case*" in terms of the records and the issues involved, but could not say whether it was the case's "*difficulty*" that in fact gave rise to this lengthy delay. Mr. F. Walsh told the Commission that he did not think that he could elaborate further in explaining the delay, save to surmise that he might have had "*some queries about sensitivities about the particular contents of the records*", saying that it was "*a particularly sensitive and troubling case...*" He accepted, however, that his job as Freedom of Information Officer was to assess whether records should have been

released or not under the legislation and that this request should have been handled “*within a reasonable period of time*”, and that it was not. In this regard, the Commission notes that delays after December, 2009 were not attributable to Mr. F. Walsh, who had completed his work on the preparation of the schedules of files for release by 15th December, 2009.

Continued delays

9.103 With respect to his review of the files received from Mr. F. Walsh between January, 2010 and the end of March, 2010, Mr. P. Walsh thought that, working from the documentation from this time, he might have gone through and cleared two of the files and was awaiting advice from the Consumer Affairs Department in relation to the third file related to Grace’s case. He believed that he had agreed with the advice received from Mr. F. Walsh in relation to the first two files. In his evidence, Mr. P. Walsh reiterated the time-consuming nature of his work at the time on “*cost containment and the actions that were needed to achieve the cost containments*”. He said that this was dragging him away from the likes of FOI issues and other routine roles. The Commission accepts that these were issues that placed particular demands on Mr. P. Walsh’s time over this period. However, Grace’s case was one with which Mr. P. Walsh was, by this stage, very familiar and in which he was very involved as a manager, as reported in Volume 1.

9.104 Mr. P. Walsh accepted that he was aware of the statutory obligations with regard to the FOI request. He also said that the delay was not acceptable and “*wasn’t a proper discharge*” of his statutory duty. However, he said that, while they were not correct, delays in FOI matters were not unusual.

Meetings between Consumer Affairs Department and Waterford Community Care staff

9.105 On 1st April, 2010, Ms B spoke with Mr. F. Walsh. He told her that he had met with Mr. P. Walsh and Ms Byrne the previous week, but that due to Mr. P. Walsh’s and Ms Browne’s annual leave, they would have to wait until the week of 19th April, 2010 to meet to go through the files. Ms B noted that Mr. F. Walsh said that it was standard for a HSE manager to sign off on a release of a file. He said that the decision would be extended by four weeks to May, 2010.

- 9.106 Ms B made a note that “[Grace’s mother] *will only be getting social work files - I requested “all files” so I will get management files also.*” This was a reference to the separate FOI request that Ms B had made on 5th March, 2010 as her Committee in wardship. Ms B said that she was clarifying with Mr. F. Walsh that, on foot of her own request, she would be getting all files relating to Grace, not just the social work files. Ms B had not seen the letter setting out Grace’s mother’s FOI request (set out above at paragraph 7.25) so she did not know, specifically, what had been requested in it.
- 9.107 This was the first time that Ms B became aware that Grace’s mother was going to receive only the social work file and the files from Day Service Provider A, and she told the Commission that she was concerned that somebody had decided to refine the scope of Grace’s mother’s FOI request to those files rather than all files relating to Grace. In this regard, the above letter which had been drafted by Mr. Smith did not curtail the request to any particular category of files.
- 9.108 Ms B said that she believed that the statement by Mr. F. Walsh that it was standard for a manager to sign off on the release of a file was made separate to the conversation about the decision-maker in the FOI (Mr. P. Walsh) and that it was made with reference to Ms Browne. Ms B said that she found it “*unusual*” that there was a requirement for Ms Browne to have an involvement prior to the release of the files or that her annual leave might delay the release of files outside the statutory timeframe. She said that Mr. F. Walsh had made this statement in response to a question she had asked specifically about Ms Browne’s involvement. In this regard, Mr. F. Walsh had referred to Ms Browne’s involvement in the planned meeting, referred to above at paragraph 9.105.
- 9.109 It was suggested to Ms B on behalf of Ms Browne that the “*HSE Manager*” referred to in her telephone call with Mr. F. Walsh on 1st April, 2010 did not relate to Ms Browne on the basis that she did not have any role in relation to the sign-off for release of files. Ms B confirmed, however, that the reference to the “*HSE Manager*” in her note of the call was to Ms Browne. Ms B also referred to the subsequent emails between Ms Browne and Mr. P. Walsh between 26th April and 28th April, 2010 which demonstrated a perceived requirement for Ms Browne to attend a meeting relating to the files prior to their release. These emails are considered below.
- 9.110 For his part, Mr. F. Walsh did not recall this conversation with Ms B on 1st April, 2010 or his meeting with Mr. P. Walsh and Ms Byrne the previous week or what was discussed there.

- 9.111 That meeting, which occurred on the 24th March, 2010, arose at the request of Ms Byrne. In this regard, Mr. F. Walsh emailed Mr. P. Walsh on 12th March, 2010 to let him know that Ms B, who had been appointed as Grace's Committee in wardship on 1st March, 2010, had now made a separate FOI request as Committee for Grace. He advised Mr. P. Walsh that Ms Byrne wanted to sit down and talk to him. In his evidence, Mr. F. Walsh said that *"I don't recall the specifics other than that we had a previous request into this matter and now this request had come in as well"*.
- 9.112 There were no notes or minutes of this meeting of 24th March, 2010 provided to the Commission. In his evidence, Mr. F. Walsh said that he was surprised that there was no record of the meeting, and also said that normally the three of them might keep notes of any actions to be done, arising from a meeting.
- 9.113 Mr. F. Walsh told the Commission that ninety *per cent* of cases would involve merely presenting files to the decision-maker and he could not recall another case in which he had met with both the decision-maker and his own line manager.
- 9.114 Ms Byrne did not recall the meeting on 24th March, 2010 with Mr. F. Walsh and Mr. P. Walsh. She said that it was not uncommon for her to meet with someone like Mr. P. Walsh prior to the release of files, although she could not say how often that would happen. In this regard, she said that a decision-maker might want *"reassurance about the approach or a specific exemption"*.
- 9.115 Mr. P. Walsh was also unable to recall this meeting.
- 9.116 On 9th April, 2010, Ms B told Grace's mother that the release was due soon and that support would be required for her.
- 9.117 On 12th April, 2010, Ms B had another telephone conversation with Grace's mother about the imminent release of files. She recorded that she told Grace's mother that she was still available to travel with the files and that she had recommended to Grace's mother that she access counselling.

Finalising FOI request

- 9.118 On 26th April, 2010, there was a series of email exchanges between Mr. F. Walsh, Mr. P. Walsh and Ms Browne in relation to Grace's case. Initially Mr. F. Walsh emailed Mr.

P. Walsh asking if they could arrange to get the FOI request finalised that week. He noted that *“As per your wishes, that means we sit down with Margaret.”* Mr. P. Walsh then wrote to Ms Browne, stating that he was *“anxious that you would get sight of what was being released to [Grace’s mother] under the FOI request, and am wondering if you have time this week to take a look, or have you enough on your plate for this week?”*

- 9.119 After a series of emails to arrange the meeting, Mr. F. Walsh emailed Mr. P. Walsh and Ms Browne on 28th April, 2010, proposing dates and stating as follows:

“Margaret, as Pat mentioned, he is anxious that you are kept thoroughly informed on this and your familiarity with what will be released under FOI is central to this whole process. There are 3 files for consideration in this release to [Grace’s mother] for this particular FOI request. Files 1 & 2 are relatively straightforward in that they deal with [Grace]’s early life. File 3 requires more consideration from an FOI and HSE perspective and what Pat is talking about is meeting to go through the file and tease out any issues that may arise. File 3 is a relatively small file (there are only 149 pages in total) with only a small number of these to be discussed.

This meeting should take no longer than an hour or so.

Please confirm what date/time and location suits ye and we’ll finalise from there.”

- 9.120 As to what he had meant by *“[f]ile 3 requires more consideration from an FOI and HSE perspective”* Mr. F. Walsh said that he would *“have to presume rather than recall that there may have been more sensitive information in it and the debate might have been whether it should have been released or not.”*

- 9.121 In his evidence, Mr. P. Walsh said that he believed that the reason that Ms Browne was invited to this meeting related to the issues that she had raised in her letters to him in January, 2010 regarding purported inaccuracies on the file. He said that he wanted advice, from Mr. F. Walsh and Ms Byrne, about Ms Browne’s concerns. He had the draft schedule prepared by Mr. F. Walsh in his possession at this stage as he

had cleared the first two files, but could not say why the third file appeared to be still with Mr. F. Walsh.

Meeting of 7th May, 2010

9.122 This meeting took place on 7th May, 2010. Mr. F. Walsh, Mr. P. Walsh, Ms Browne, and Ms Byrne were in attendance. It appears that there were no notes or minutes of this meeting.

9.123 Mr. P. Walsh said that he could not recall the discussion at this meeting. He believed, however, that they would have discussed all of Ms Browne's concerns, in a general context, whether they were in relation to files that were due to be released or not. The Commission is satisfied that, in all likelihood, this was a broad discussion on what would be released to Grace's mother under FOI, not least having regard to the observation by Mr. F. Walsh in his email of 28th April, 2010, referred to at paragraph 9.119 above, about Mr. P. Walsh's view that Ms Browne's familiarity with what was to be released was central to the process. Mr. P. Walsh said that to the best of his recollection, Mr. F. Walsh's recommendations, as set out in the schedule in relation to the release of files, were adopted by him.

9.124 Mr. F. Walsh could not recall any detail in relation to the reason for the meeting or the meeting itself. He accepted that he should have made a record of what transpired at it and could not say why that was not done. He told the Commission that, in general, he would have made a note.

9.125 Ms Browne could not recall this meeting. She said, however, that, from her perspective, her impression about its purpose was that it was to be about the letter that she had written to Mr. P. Walsh about what she considered to be inaccuracies on the file. She said that she could not recall ever having seen the schedule of documents to be released. While accepting that it was "*generally*" her practice to take notes of meetings, Ms Browne could not recall if she made a note of this meeting. She said that, at the time, she was preoccupied as she was due to be interviewed by the Conal Devine Inquiry.

9.126 Ms Browne said that it was not common for her to attend meetings such as this one. She said that her only concern, insofar as Grace's mother's FOI request was concerned, related to the issue of the accuracy of the file, and suggested that her

voicing of dissatisfaction in relation to the accuracy of certain entries was the reason for her involvement in the meeting. Ms Browne said that she had no involvement in the final sign off on the release of files on foot of the FOI request. Ms Browne agreed that this was regarded as a complex and sensitive case and said that she would have felt that the release of sensitive files to Grace's mother would have been upsetting to her. In this regard, the Commission is satisfied that Ms Browne, who had interacted with Grace's mother for the purpose of obtaining a consent from her (which was relied upon by the HSE as an authority to move Grace), was acutely aware of the limit of the information that Grace's mother had been previously given. Mr. P. Walsh was also aware of the position in that regard. The concerns within the HSE with respect to the provision of information to Grace's mother, throughout the management of Grace's case, are considered in detail in Volume 1.

9.127 Owing to the fact that, unusually, there was an absence of any notes of the meeting, and in view of the absence of memory of the attendees, the Commission had no evidence as to the detail of the discussion at the meeting concerning what was to be released to Grace's mother.

9.128 However, the emails that passed between Mr. P. Walsh, Ms Browne, and Mr. F. Walsh before the meeting underlined the ongoing concern regarding what documents would be released to Grace's mother, and the Commission is satisfied that this concern included the release of material that was potentially sensitive from the HSE's perspective. The Commission also notes that, from the perspective of Mr. P. Walsh and Ms Browne, this meeting occurred against the background of Grace's mother's having been previously provided with very limited information by the HSE about the history of the SEHB/HSE's management of Grace's case, when the HSE was engaging with her prior to Grace's move into a residential placement in July, 2009. This aspect of the management of Grace's case is reported upon extensively in Part 2 of Volume 1. The Commission is satisfied that, in all likelihood, this, together with Ms Browne's concern about what she considered to be inaccuracies in some of Mr. Smith's notes on the files referable to her involvement in Grace's case, formed the subject matter of this meeting.

The issue of who was to receive the released files

9.129 On 29th April, 2010 Ms B telephoned the Freedom of Information Unit and was told that the files were to be released directly to Grace's mother by registered post within the

week beginning 10th May, 2010. She noted that Mr. P. Walsh was making the decision regarding that. Ms B noted that she expressed concern about doing this due to Grace's mother's emotional state and the lack of support. Mr. F. Walsh had no recollection of this conversation with Ms B.

9.130 Ms B updated Grace's mother, advising her that Mr. F. Walsh would be meeting with the HSE managers on 7th May, 2010 and that the files would be released during the week beginning 10th May, 2010. Ms B said that the files would likely be sent in the post to her but Grace's mother wanted Ms B to bring the files to her. Ms B told her that Mr. P. Walsh was the decision-maker but that even if the files were sent to Grace's mother she, Ms B, could travel to be there to go through them with her when they arrived. Ms B also noted that she agreed to follow up on Grace's mother's complaint about delay with respect to the FOI request.

9.131 Ms B told the Commission that the fact that the files would now be sent directly to Grace's mother was *"quite unexpected"* as, she said, everything had been planned in a particular way (with her to receive the files for Grace's mother) for a month.

9.132 On 10th May, 2010 Ms B wrote to Mr. P. Walsh, copied to Mr. F. Walsh, to register her disappointment that the FOI files were to be sent directly to Grace's mother rather than to her (Ms B), as requested. She noted that in September, 2009, Mr. F. Walsh had suggested that it would be more appropriate for the files to be released to somebody who could provide support to Grace's mother in reading through them, that she had agreed to this, and had put this request in writing to Mr. F. Walsh. She set out a series of bullet points relating to why the files should be released through her:

- *"In my professional opinion, it is not appropriate or responsible for this information to be released to [Grace's mother] in this manner*
- *The HSE's Social Work Team Leader, Iain Smith, following a request for information I made on behalf of [Grace's mother], has stated that he would rather provide any sensitive information to [Grace's mother] in a supported manner, rather than in writing or by telephone*

- [Grace's mother] *has herself recognised the distress and upset she is experiencing at present, and is likely to experience following the release of the files, and had requested that I provide support to her in relation to this*
- [Grace's mother] *has also sought further counselling owing to the distress she expects that the release of the files will cause".*

9.133 Mr. P. Walsh discussed this letter with Mr. F. Walsh and then directed that the files should be released through Ms B.

9.134 On 11th May, 2010, Mr. F. Walsh confirmed to Ms B that the files were to be released to her and she arranged to meet him to collect the files. The files were collected and Ms B made a note that Mr. F. Walsh explained to her the schedules, and the information not released and why it had been exempted, so that she would be in a position to explain this to Grace's mother.

9.135 Mr. F. Walsh had no recollection of handing the files to Ms B or having a conversation with her regarding the information not released.

9.136 Ms B told the Commission that, when she viewed the files with Mr. F. Walsh, she was concerned at the number of redactions she noticed on the documents. She noted that third party data that might have been relevant to Grace had been redacted. She said that Mr. F. Walsh told her that a lot of interesting information had been taken off the files (by way of redaction as *per* the provisions of FOI legislation), but that he presumed she had a greater knowledge of the case and mentioned some of the redacted information to her (such as redactions from Mr. Smith's reports, which reports are fully reported in Volume 1) on that basis. Ms B said that that was the nature of the discussion that she had with Mr. F. Walsh.

9.137 Ms B told the Commission that she told Grace's mother on 12th May, 2010 that much of the information had been taken off the files for various reasons. Ms B was to travel to England on the following Wednesday to bring her the released material from the files.

9.138 With respect to the above, Ms Byrne gave evidence to the Commission regarding the process involved in determining what could be released under FOI when third-party

data was involved. She described the approach taken as very nuanced and said (by way of example) that if there was commentary in a document being considered for release referring to a person in care in a placement which related to what allegedly-had happened to other persons in care in that placement, then *“all of that information would be blacked out because it's what we call "joint personal information" in the law. So if it reveals information of a third party, if it reveals personal information of somebody else, then the FOI Act says no [exempt]”*.

9.139 Ms Byrne told the Commission that, in that regard, the information redacted by her Unit could be with respect to both the possible identification of another person, or to the fact that something was alleged to have happened.

Ms B delivers files released to Grace's mother

9.140 On 31st May, 2010, Ms B visited Grace's mother in England to provide her with the files released on foot of her FOI request and to read through them with her.

Grace's mother writes to Mr. Halpin regarding her complaint

9.141 Following Ms B's visit, Grace's mother wrote to Mr. Halpin in relation to her previous complaint stating:

“I am writing in relation to the complaint that I made to your office concerning the Freedom of Information request I had submitted (re: my daughter [Grace]).

Could you please advise me of the following:

- The name of the designated complaints officer who has been assigned to deal with my complaint*
- The date by which I can expect to hear the outcome of the inquiry into my complaint*

Please note that I am mindful that the statutory timeframes in relation to such complaints under the Health Act have not, thus far, been adhered to.

I look forward to hearing from you.”

- 9.142 Ms B brought this letter in draft form for Grace’s mother’s approval when she visited her with the released files. She said that the primary driver for the letter was the volume of redactions that she, Ms B, had observed on Grace’s files.
- 9.143 Mr. Halpin did not recall receiving this letter. He said that he did not have a general practice for when he received letters such as this. However, he said that, when reading this letter which related to the original complaint, he would have known that the FOI decision had been released earlier that month. Mr. Halpin believed that he would have reflected that, perhaps, this letter and the issuing of the decision had *“crossed in the post”* and *“would have thought that the issue that had been raised had been resolved.”* Essentially, he believed that Grace’s mother’s complaint had been resolved when the FOI decision issued. He agreed that he did not consider the information sought in the letter to be relevant any longer in those circumstances.
- 9.144 Mr. Halpin acknowledged in his evidence that Grace’s mother’s letter was seeking more than just the issuing of the FOI decision. While he surmised that he would have provided her with a written response containing an apology for delay, there was no such letter in the documentation provided to the Commission.
- 9.145 Ms Byrne could not recall whether her attention was ever brought to the fact that there was a follow up letter of complaint made by Grace’s mother. She said that whether or not she was made aware of a particular complaint would depend on the content of it. Generally, complaints were dealt with under the particular service. Ms Byrne said that under Part 9 of the Health Act, 2007, complaints officers were assigned in each location and complaints were dealt with by them. Mr. Halpin was the assigned relevant complaints officer.
- 9.146 Mr. P. Walsh did not recall any discussion with Mr. Halpin in relation to the complaint.
- 9.147 As is evident from the text of both the letter of complaint and the follow up letter, these letters sought more than the completion of the FOI process, but called for an explanation for the inordinate delay regarding the processing of same. The Commission is satisfied that the complaint made by Grace’s mother about a 20 month delay in the processing of her FOI request required a response and a proper

explanation from the HSE as to the reason for this delay in her case. She did not get either. This was a failing on the part of the HSE.

Request for internal review

9.148 Ms B told the Commission that she was very concerned in relation to the level of redaction in the released files. She thought that information to which she felt Grace's mother was entitled had been subject to unwarranted redaction. Ms B was concerned that documents relevant to Grace's care, for instance, those related to the management of her case in 1996 containing information about the allegation made on behalf of another party at that time (which led to a decision, subsequently reversed, to move Grace from the placement, as reported in the First Substantive Interim Report), had been significantly redacted on the basis that it contained third-party data. Ms B said that she thought that the HSE had been very liberal with the redactions on the files. These were concerns that she raised with Mr. F. Walsh at this time and were the basis for the request for an internal review of the FOI decision. Ms Byrne's evidence about the extent of the redaction of third-party information in the FOI process has been reported upon above at paragraphs 9.138 and 9.139 above.

9.149 On 3rd June, 2010 Ms B spoke to Grace's mother to confirm that she requested an internal review of the files provided to her under FOI. Ms B told her that there was a letter to Mr. Halpin ready to go to in the post for her to sign.

9.150 Ms B also wrote to Ms Byrne on that date, stating that, having viewed the files released to her in May, 2010, Grace's mother requested an internal review.

9.151 Ms Byrne assigned this review to the delegated internal reviewer who, in this instance, was Mr. Halpin.

9.152 Mr. Halpin duly received a copy of the letter sent by Grace's mother seeking the review. He told the Commission that the process for internal reviews at the time was that Ms Byrne would *"do the groundwork, the legwork, in relation to compiling the relevant material and documentation, probably undertaking the review of the original decision having regard to whatever submissions, if any, were made in relation to the basis of seeking the internal review."* Ms Byrne would then liaise with him as the internal reviewer to progress the matter, with a focus on the material that had not been released originally. He did not have a memory of dealing with this review but said that Ms Byrne

would also draft a letter for him with respect to the proposed outcome of the internal review, which he would look at along with all of the relevant material. Ultimately, he would sign the letter with the outcome of the review.

- 9.153 On 8th June, 2010, Ms B made a note of a telephone conversation with Grace's mother who wanted to know what had happened in 1996. Ms B asked if Grace's mother would like to talk to Mr. Smith, as a lot of the information in Grace's case would only be available from the HSE, and she was agreeable to doing so.
- 9.154 On 11th June, 2010, Ms Byrne contacted Ms B to ask why Grace's mother would like an internal review. Ms B told her that Grace's mother felt that more information should have been released on foot of the FOI request. While Ms Byrne did not recall this conversation, she said that it was "*common practice*" to seek reasons for the internal review in order to assist the internal review process. Her office would, she said, have contacted Mr. Halpin on this.
- 9.155 On 14th June, 2010, Ms Byrne wrote to Ms B with respect to the request for internal review under s. 14 of the 1997 Act. The letter stated that the internal review process involved a complete reconsideration of this matter by a more senior member of staff and that Mr. Halpin would be the internal reviewer. Ms Byrne said that a decision would normally be given within three weeks of that letter. She said that this was a standard letter signed by her and that administrative support in her office would have likely generated the letter for transmission to Mr. Halpin.
- 9.156 With respect to the conduct of an internal review, Ms Byrne explained that she would review the files to see if anything had changed because sometimes, depending on the exemptions used, there might be a change in circumstances. For instance, exemptions that had been applied because of an ongoing investigation or a deliberative process would be directly affected by the passage of time and would require a further review then to see if that had changed anything in the decision. The question would then arise as to whether there was more information that could be released. The internal review would also involve consideration of whether or not the exemptions were appropriately and consistently applied.
- 9.157 Ms Byrne said that sometimes the variation following review would involve simply changing the exemption applied to protect documents from release.

- 9.158 In her evidence to the Commission, Ms Byrne reiterated what she described as the limitations of the FOI process and the information that might be redacted in the course of the process. In this regard, she reiterated that any personal information or allegations relating to third parties would not have been released under the FOI process.
- 9.159 On 15th June, 2010, Ms B noted a telephone call from Grace's mother who had spoken with Mr. Smith. During this conversation, Mr. Smith had revealed to Grace's mother, among other things, that in 1996 there had been allegations against Mr. X of sexual abuse of another person. Grace's mother wanted to send a letter of complaint that she and Ms B had been working on, to someone high up in the HSE as soon as possible. It was decided to send the letter to Ms Anna Marie Lanigan, Interim Assistant National Director of Primary, Community and Continuing Care, HSE South in Cork. Grace's mother had received no response from Mr. Halpin regarding the complaint about delay. Ms B advised Grace's mother that she was now entitled to make a complaint to the Consumer Affairs Department should she wish to do so.
- 9.160 Ms B said that she had made notes of every issue that Grace's mother had with the files as she went through them. She said that it took some time to collate these issues. This letter of complaint, drafted by Ms B for Grace's mother, was completed around 22nd June, 2010. Ms B told the Commission that following Mr. Smith's telephone call to Grace's mother, she had telephoned Ms B late one evening. Ms B described her as distraught by the information she had received from Mr. Smith, which had been exempted from the material released to her under FOI.
- 9.161 Mr. Halpin accepted that by this time, mid-June, 2010, he had yet to give a substantive response to Grace's mother's complaint letter sent on 15th March, 2010, although he reiterated that he believed that it had been responded to by the action of issuing a decision on the FOI request. As noted above at paragraph 9.97, the Commission has found that this was not a response to the complaint made and no explanation had been offered with respect to the inordinate delay in dealing with the FOI request.

Letter sent to Ms Lanigan

- 9.162 On 26th June, 2010, the letter was sent by Grace's mother to Ms Lanigan. This letter noted that files had recently been released to her arising from her FOI request and stated that *"I requested these files in July 2008, and received them in May 2010. I have*

made a complaint in relation to this delay to the [Local Health Manager], Mr Dermot Halpin, but thus far a complaints officer has not been appointed to deal with my complaint." The letter also detailed Grace's mother's distress and upset at issues to do with the management of Grace's case by the SEHB/HSE and her care, having read the material that was released to her pursuant to her FOI request. This included the fact that Grace had remained in the Family X placement despite allegations of sexual abuse of a third party having arisen in 1996, the lack of monitoring of her placement, and the fact that Grace's mother had not been given correct information for the purposes of giving informed consents. It also raised many queries with respect to the actions and inaction of the SEHB/HSE as evidenced from her reading of the released material.

- 9.163 Mr. Halpin said that he could not recall whether or not this letter was brought to his attention, though he said that he had some recollection that *"the more substantive element of the correspondence was something that I think Ms Lanigan was going to address in the context of the ongoing review that was happening at that time."* Mr. Halpin thus did not undertake any inquiry into the delay in the processing of Grace's mother's FOI request arising from this letter.

Outcome of internal review

- 9.164 Three weeks later, on 5th July, 2010, Ms Byrne emailed Ms B attaching a copy of the schedules as requested, following the internal review. The email stated that the files would be sent by registered post the following day to Grace's mother.
- 9.165 The provision of these schedules of documents in July, 2010, on completion of the internal review, was the last step taken in the processing of Grace's mother's FOI request within the HSE.
- 9.166 The internal review was conducted within the statutory timeframe.

10. Findings

- 10.1 The evidence considered with regard to the processing of and response by the HSE to Grace's mother's request for documentation under the Freedom of Information Act, has been set out above in a step-by-step fashion. The periods of inaction and delay with respect to the processing of this request and the reasons why documents on foot

of it were not provided to Grace's mother for a period of two years are reported in the context in which that inaction and delay arose over that period.

10.2 The Commission is satisfied that this delay and stalling in the progress of the request were contributed to by a combination of the factors established by the evidence and summarised below.

10.3 Without detracting from the detail reported above, the Commission is satisfied that the reasons why documents on foot of the FOI request were not provided to Grace's mother for a period of two years arose from a combination of the following factors:

- the particular interest of Ms Browne and Mr. Smith, arising from their long-standing involvement in Grace's case, which was immediately conveyed to Mr. F. Walsh and the Freedom of Information Unit on receipt by that Unit of Grace's mother's FOI request. The Commission is satisfied that this led to an unusual level of contact between management within Waterford Community Care and the Freedom of Information Unit in connection with Grace's mother's FOI request arising from an apprehension about what could be released to Grace's mother on foot of her request;
- the fact that Mr. F. Walsh was contacted by Ms Browne and Mr. Smith after the FOI request was received, and had drawn to his attention the sensitivities and complexities of Grace's case and the perceived sensitivities around the release of information to Grace's mother;
- the concerns of Mr. P. Walsh that a FOI request had been made by Grace's mother in the first place, referred to by him as "*her renewed interest in the case*", which the Commission is satisfied was regarded as a complication in the management of Grace's case;
- the concerns of Mr. P. Walsh and Ms Browne about what information might be released to Grace's mother in the FOI process, which the Commission considers cannot be divorced from the fact that limited information had been released to her for the purpose of securing her consent which was relied upon by the HSE as purported authority to move Grace from her placement;

- the concerns that the release of information to Grace's mother about the history of the management of Grace's case might upset her and hamper the HSE's plan to move Grace in reliance upon that consent which had been given to the HSE, based on limited information provided to Grace's mother;
- the concerns of Mr. P. Walsh and Ms Browne to discuss with Mr. F. Walsh and Ms Byrne what material was going to be recommended to Mr. P. Walsh for release to Grace's mother. This included the question of addressing Ms Browne's concerns that there were inaccuracies in the files to be corrected before material was released; and
- the question of addressing whether the material to be released under the FOI process was to be sent directly to Grace's mother or to Ms B on her behalf.

10.4 The Commission is satisfied on the evidence that the above factors, when seen in the context of the evidence reported above concerning the manner in which Grace's mother's FOI request was progressed, significantly contributed to the delays (often unexplained) in the processing of that request.

10.5 The Commission also found that there were other factors that contributed to delays in the progressing of the request, as follows:

- time was required to gather in the files related to Grace for consideration of the FOI request. This had not occurred before the statutory time period for the consideration of the request pursuant to the 1997 Act, a period of four weeks, had expired. This was not an unreasonable delay in the circumstances and the Commission is satisfied that there was no reality to an expectation that this FOI request could have been reasonably completed within that timeframe; and
- the Commission also accepts the evidence of the pressure of workloads within the Freedom of Information Unit in dealing with requests as it related to this period of time, and further accepts that delays in the processing of FOI requests were not uncommon. The Commission also accepts that there were significant work pressures on Mr. P. Walsh in other areas, in particular in the area of addressing cost containment issues, around the time that he had duties as a decision-maker with respect to this FOI request.

10.6 However, as reported in this Volume, there were unexplained and unaccounted for periods of delay, not clearly attributable to the above factors, and the Commission is satisfied that the delay in the processing of the request was not normal and was inordinate in the circumstances.

END

APPENDIX

1. Section 4 of the 1997 Act related to the delegation of functions by the head of a public body. It stated:

“4.—(1) A head may delegate in writing to a member of the staff of the public body concerned any of the functions of the head under this Act (other than this section and section 25).

(2) A delegation under subsection (1) (‘a delegation’) may—

(a) relate to functions generally or specified functions or be in respect of records generally or specified classes of records or specified records, and

(b) be to a specified member or specified members of the staff of the public body concerned or to such members who are of a specified rank or grade or of a rank or grade not lower than a specified rank or grade,

and may delegate different functions or classes of function to different such members or classes of members.

(3) A delegation may be revoked in whole or in part or amended in writing by the head for the time being of the public body concerned.

(4) A delegation shall operate, so long as it continues in force, to confer on and vest in the person concerned the function or functions delegated by the delegation.

(5) The head concerned shall cause notice of a delegation or of a revocation or amendment under subsection (3) to be published in Iris

*Oifigiúil not later than 4 weeks after the making of the delegation, revocation or amendment, as the case may be.*³

(6) References in this Act to a head shall be construed, where appropriate having regard to the context and any delegation under this section, as including references to any person to whom functions stand delegated by the delegation.”

2. Section 6 of the 1997 Act, as amended⁴, concerned the accessing of information. It stated:

“6.—(1) Subject to the provisions of this Act, every person has a right to and shall, on request therefor, be offered access to any record held by a public body and the right so conferred is referred to in this Act as the right of access.

(2) It shall be the duty of a public body to give reasonable assistance to a person who is seeking a record under this Act—

(a) in relation to the making of the request under section 7 for access to the record, and

(b) if the person has a disability, so as to facilitate the exercise by the person of his or her rights under this Act.

(3) The Minister shall, after consultation with such other (if any) Ministers of the Government as he or she considers appropriate, draw up and publish to public bodies guidelines in relation to compliance by public bodies with subsection (2)(b), and public bodies shall have regard to any such guidelines.

(4) The records referred to in subsection (1) are records created after the commencement of this Act and—

³ Section 4(5) was deleted by s. 3 of the Freedom of Information (Amendment) Act 2003.

⁴ References in s. 6(4), s. 6(5), s. 6(6) and s. 6(9) as construed by S.I. Nos 516 and 517 of 1998. The former construed “commencement of the Act” in relation to local authorities and health boards as meaning 21st October, 1998. Section 6 was amended by s. 4 of the Freedom of Information (Amendment) Act 2003 with the insertion of s. 6(11).

(a) records created during such period (if any), or after such time (if any), before the commencement of this Act, and

(b) records created before such commencement and relating to such particular matters (if any), and

(c) records created during such period (if any) and relating to such particular matters (if any),

as may be prescribed, after consultation with such Ministers of the Government as the Minister considers appropriate.

(5) Notwithstanding subsections (1) and (4) but subject to subsection (6), where—

(a) access to records created before the commencement of this Act is necessary or expedient in order to understand records created after such commencement, or

(b) records created before such commencement relate to personal information about the person seeking access to them,

subsection (1) shall be construed as conferring the right of access in respect of those records.

(6) Subsection (5) shall not be construed as applying, in relation to an individual who is a member of the staff of a public body, the right of access to a record held by a public body that—

(a) is a personnel record, that is to say, a record relating wholly or mainly to one or more of the following, that is to say, the competence or ability of the individual in his or her capacity as a member of the staff of a public body or his or her employment or employment history or an evaluation of the performance of his or her functions generally or a particular such function as such member,

(b) was created more than 3 years before the commencement of this Act, and

(c) is not being used or proposed to be used in a manner or for a purpose that affects, or will or may affect, adversely the interests of the person.

(7) Nothing in this section shall be construed as applying the right of access to an exempt record.

(8) Nothing in this Act shall be construed as prohibiting or restricting a public body from publishing or giving access to a record (including an exempt record) otherwise than under this Act where such publication or giving of access is not prohibited by law.

(9) A record in the possession of a person who is or was providing a service for a public body under a contract for services shall, if and in so far as it relates to the service, be deemed for the purposes of this Act to be held by the body, and there shall be deemed to be included in the contract a provision that the person shall, if so requested by the body for the purposes of this Act, give the record to the body for retention by it for such period as is reasonable in the particular circumstances.

(10) Where a request under section 7 would fall to be granted by virtue of subsection (9) but for the fact that it relates to a record that contains, with the matter relating to the service concerned, other matter, the head of the public body concerned shall, if it is practicable to do so, prepare a copy, in such form as he or she considers appropriate of so much of the record as does not consist of the other matter aforesaid and the request shall be granted by offering the requester access to the copy.

(11) (a) In subsection (4) to (6), 'commencement of this Act', in relation to local authorities and health boards, means 21 October, 1998.

(b) In subsection (9), 'person' does not include a public body or any other body, organisation or group that is specified in clauses (a) to (g) of subparagraph (5) of paragraph 1 of the First Schedule and does not

stand prescribed for the time being for the purposes of that subparagraph.”

3. Section 7 of the 1997 Act concerned requests for access to records. It stated:

“7.—(1) A person who wishes to exercise the right of access shall make a request, in writing or in such other form as may be determined, addressed to the head of the public body concerned for access to the record concerned—

(a) stating that the request is made under this Act,

(b) containing sufficient particulars in relation to the information concerned to enable the record to be identified by the taking of reasonable steps, and

(c) if the person requires such access to be given in a particular form or manner (being a form or manner referred to in section 12), specifying the form or manner of access.

(2) The head shall cause the receipt by him or her of a request under subsection (1) to be notified, in writing or in such other form as may be determined, to the requester concerned as soon as may be but not later than 2 weeks after such receipt, and the notification shall include a summary of the provisions of section 41 and particulars of the rights of review under this Act, the procedure governing the exercise of those rights, and the time limits governing such exercise, in a case to which that section applies.

(3) Where a request under this section is received by the head of a public body (‘the head’) and the record or records concerned is or are not held by the body (‘the first-mentioned body’) but, to the knowledge of the head, is or are held by one or more other public bodies, the head shall, as soon as may be, but not more than 2 weeks, after the receipt of the request, cause a copy of the request to be given to the head of the other body or, as the case may be, to the head of that one of the other bodies—

(a) whose functions are, in the opinion of the head, most closely related to the subject matter of the record or records, or

(b) that, in the opinion of the head, is otherwise most appropriate,

and inform the requester concerned, by notice in writing or in such other form as may be determined, of his or her having done so and thereupon—

(i) the head to whom the copy aforesaid is furnished shall be deemed, for the purposes of this Act, to have received the request under this section and to have received it at the time of the receipt by him or her of the copy, and

(ii) the head shall be deemed, for the purposes of this Act, not to have received the request.

(4) Where a request under this section relating to more than one record is received by the head of a public body ('the first-mentioned body') and one or more than one (but not all) of the records concerned is or are held by the body, the head shall inform the requester concerned, by notice in writing or in such other form as may be determined, of the names of any other public body that, to his or her knowledge, holds any of the records.

(5) The Minister shall, after consultation with the Commissioner, draw up and publish to heads guidelines for the purposes of subsection (3) and (4) and heads shall have regard to any such guidelines.

(6) A person shall be deemed to have the knowledge referred to in subsection (3) and (4) if, by the taking of reasonable steps, he or she could obtain that knowledge.

(7) Where—

(a) a person makes a request for information, or a request for access to a record, to a public body or to a head or a director, or member of the

staff, of a public body, other than under and in accordance with this Act, and

(b) it is not or may not be possible to give the information, or make available the record, other than pursuant to a request in relation to it under and in accordance with section 7,

the head shall, if appropriate, cause the person to be informed of the right of access and shall assist, or offer to assist, the person in the preparation of such a request.

(8) A person who makes a request under subsection (1) may, at any time before the making of a decision under section 8(1) in relation to the request, by notice in writing or in such other form as may be determined, given to the head concerned, withdraw the request and the head concerned shall cause notice of the withdrawal to be given to any other person to whom, in the opinion of the head, it should be given.”⁵

4. Section 8 of the 1997 Act concerned decisions relating to requests made under s. 7 of the Act. It stated:

“8.—(1) Subject to the provisions of this Act, a head shall, as soon as may be, but not later than 4 weeks, after the receipt of a request under section 7—

(a) decide whether to grant or refuse to grant the request or to grant it in part,

(b) if he or she decides to grant the request, whether wholly or in part, determine the form and manner in which the right of access will be exercised, and

(c) cause notice, in writing or in such other form as may be determined, of the decision and determination to be given to the requester concerned.

⁵ Section 7(8) was inserted by s. 5 of the Freedom of Information (Amendment) Act 2003, and was commenced on enactment.

(2) A notice under subsection (1) shall specify—

(a) the decision under that subsection concerned and the day on which it was made,

(b) unless the head concerned reasonably believes that their disclosure could prejudice the safety or well-being of the person concerned, the name and designation of the person in the public body concerned who is dealing with the request,

(c) if the request aforesaid is granted, whether wholly or in part—

(i) the day on which, and the form and manner in which, access to the record concerned will be offered to the requester concerned and the period during which the record will be kept available for the purpose of such access, and

(ii) the amount of any fee under section 47 payable by the requester in respect of the grant of the request,

(d) if the request aforesaid is refused, whether wholly or in part—

(i) the reasons for the refusal, and

(ii) unless the refusal is pursuant to section 19(5), 22(2), 23(2), 24(3), 26(4), 27(4) or 28(5A)⁶, any provision of this Act pursuant to which the request is refused and the findings on any material issues relevant to the decision and particulars of any matter relating to the public interest taken into consideration for the purposes of the decision,

(e) if the giving of access to the record is deferred under section 11, the reasons for the deferral and the period of the deferral, and

(f) particulars of rights of review and appeal under this Act in relation to the decision under subsection (1) and any other decision referred to in

⁶ The references in s. 8(2)(d)(ii) to s. 26(4), s. 27(4) and s. 28(5A) were inserted by s. 6 of the Freedom of Information (Amendment) Act 2003.

the notice, the procedure governing the exercise of those rights and the time limits governing such exercise.

(3) Subject to the provisions of this Act, where a request is granted under subsection (1)—

(a) if—

(i) a fee is not charged under section 47 in respect of the matter,

(ii) a deposit under that section has been paid and a fee under that section is charged and the amount of the deposit equals or exceeds the amount of the fee, or

(iii) such a deposit has been paid but such a fee is not charged,

access to the record concerned shall be offered to the requester concerned forthwith and the record shall be kept available for the purpose of such access for a period of 4 weeks thereafter, and

(b) if a fee is so charged, access to the record concerned shall be offered to the requester concerned as soon as may be, but not more than one week, after the day on which the fee is received by the public body concerned, and the record shall be kept available for the purpose of such access until—

(i) the expiration of the period of 4 weeks from such receipt, or

(ii) the expiration of the period of 8 weeks from the receipt by the requester concerned of the notice under subsection (1) concerned,

whichever is the earlier.

(4) Subject to the provisions of this Act, in deciding whether to grant or refuse to grant a request under section 7—

(a) any reason that the requester gives for the request, and

(b) any belief or opinion of the head as to what are the reasons of the requester for the request,

shall be disregarded.⁷

(5) This section shall not be construed as requiring the inclusion in a notice under subsection (1) of matter that, if it were included in a record, would cause the record to be an exempt record.

(6) References in this section to the grant of a request under section 7 include references to such a grant pursuant to section 13.”

5. Section 9 of the 1997 Act concerned extensions of time for considering requests under s.7 of the Act. It stated:

“9.—(1) The head may, as respects a request under section 7 received by him or her (‘the specified request’), extend the period specified in section 8 (1) for consideration of the request by such period as he or she considers necessary but not exceeding a period of 4 weeks if in the opinion of the head—

(a) the request relates to such number of records, or

(b) the number of other requests under section 7 relating either to the record or records to which the specified request relates or to information corresponding to that to which the specified request relates or to both that have been made to the public body concerned before the specified request was made to it and in relation to which a decision under section 8 has not been made is such,

that compliance with that subsection within the period specified therein is not reasonably possible.

(2) Where a period is extended under this section, the head concerned shall cause notice in writing or in such other form as may be determined,

⁷ Section 8(4) was amended by s. 6 of the Freedom of Information (Amendment) Act 2003.

to be given to the requester concerned, before the expiration of the period, of the extension and the period thereof and reasons therefor.

(3) The reference in section 8 (1) to 4 weeks shall be construed in accordance with any extension under this section of that period.”

6. Section 14 of the 1997 Act concerned reviews by heads of decisions. It stated:

“14.—(1) This section applies to a decision made pursuant to this Act by a person to whom the function concerned stood delegated at the time of the making of the decision, being—

(a) a decision to refuse to grant a request under section 7, whether wholly or in part, (other than a request to which section 29 applies) (‘a request’) in relation to the record concerned,

(b) a decision under section 11 to defer the offering of access to a record falling within paragraph (a) of subsection (1) of that section,

(c) a decision under section 12 to grant a request by giving access to the record concerned in a form other than that specified in the request,

(d) a decision under section 13 to grant a request under section 7 by offering the requester concerned access to a copy of part only of the record concerned,

(e) a decision under section 17 to refuse to amend a record,

(f) a decision under section 18 in relation to the contents of a statement furnished under subsection (1) of that section or to refuse an application under that subsection, or

(g) a decision to charge a fee or deposit, or a fee or deposit of a particular amount, under section 47.

(2) Subject to the provisions of this section, the head of the public body concerned, on application to him or her in that behalf, in writing or in such other form as may be determined, by a relevant person—

(a) may review a decision to which this section applies, and

(b) following the review, may, as he or she considers appropriate—

(i) affirm or vary the decision, or

(ii) annul the decision and, if appropriate, make such decision in relation to the matter as he or she considers proper,

in accordance with this Act.

(3) A person to whom a function under this section stands delegated under section 4 shall not perform that function in relation to a decision to which this section applies that was made by a member of the staff of the public body concerned whose rank is the same as or higher than that of the person aforesaid.

(4) A decision under subsection (2) shall be made, and the head concerned shall cause notice thereof, in writing or in such other form as may be determined, to be given to the relevant person and any other person whom he or she considers should be notified thereof, not later than 3 weeks after the receipt by the head of the application for the review under that subsection concerned.

(5) A notice under subsection (4) shall specify—

(a) the day on which the decision concerned under that subsection was made,

(b) if the decision is to grant, in whole or in part, the request under section 7 concerned, the information referred to in section 8 (2)

(c),

(c) if the decision is to refuse to grant, wholly or in part, the request aforesaid, the information specified in subparagraph (i) of paragraph (d) of section 8 (2) and, if the refusal is not pursuant to section 10(1)(c), 19(5), 22(2), 23(2), 24(3), 26(4), 27(4) or 28(5A)⁸, the information specified in subparagraph (ii) of that paragraph,

(d) if the decision is to defer the giving of access to the record concerned, the reasons for the deferral and the period of the deferral,

(e) if the decision is a decision referred to in paragraph (c), (d), (e), (f) or (g) of subsection (1), the reasons for the decision, and

(f) particulars of the rights of review and appeal under this Act in relation to the decision, the procedure governing the exercise of those rights and the time limits governing such exercise.

(6) This section shall not be construed as requiring the inclusion in a notice under subsection (4) of matter that, if it were included in a record, would cause the record to be an exempt record.

(7) An application under subsection (2) shall be made not later than 4 weeks after the notification under this Act of the decision concerned to the relevant person concerned or, in a case in which the head concerned is of the opinion that there are reasonable grounds for extending that period, the expiration of such longer period as he or she may determine.

(8) The relevant person concerned may, at any time before the making of a decision under subsection (2) following the review concerned, by notice in writing or in such other form as may be determined, given to the head concerned, withdraw the application concerned under that subsection and the head concerned shall cause a copy of any notice

⁸ Section 14(5)(c) was amended by s. 9 of the Freedom of Information (Amendment) Act 2003; the amendments were commenced on enactment.

*given to him or her under this subsection to be given to any other person to whom, in the opinion of the head, it should be given.*⁹

(9) Subsection (3) of section 8 shall apply in relation to a case where a decision under subsection (2) is to grant a request under section 7 or to annul or vary a deferral under section 11 with the modification that the reference in the said subsection (3) to the grant of a request under subsection (1) of section 8 shall be construed as a reference to the making of the decision under subsection (2).

(10) Subject to the provisions of this Act, a decision under subsection (2) shall—

(a) in so far as it is inconsistent with the decision to which this section applies concerned, have effect in lieu thereof, and

(b) be binding on the parties concerned.

(11) In this section ‘relevant person’, in relation to a decision to which this section applies, means—

(a) the requester concerned, or

(b) if the decision is under section 17 or 18, the person who made the application concerned.”

7. Section 28 of the 1997 Act related to personal information. It stated:

“28.—(1) Subject to the provisions of this section, a head shall refuse to grant a request under section 7 if, in the opinion of the head, access to the record concerned would involve the disclosure of personal information (including personal information relating to a deceased individual).

⁹ Section 14(8) was amended by s. 9 of the Freedom of Information (Amendment) Act 2003 by substituting the text set out for the previously enacted text; the amendment was commenced on enactment.

(2) Subsection (1) does not apply if—

(a) subject to subsection (3), the information concerned relates to the requester concerned,

(b) any individual to whom the information relates consents, in writing or such other form as may be determined, to its disclosure to the requester,

(c) information of the same kind as that contained in the record in respect of individuals generally, or a class of individuals that is, having regard to all the circumstances, of significant size, is available to the general public,

(d) the information was given to the public body concerned by the individual to whom it relates and the individual was informed on behalf of the body, before its being so given, that the information belongs to a class of information that would or might be made available to the general public, or

(e) disclosure of the information is necessary in order to avoid a serious and imminent danger to the life or health of an individual,

but, in a case falling within paragraph (a) or (b), the head concerned shall ensure that, before the request under section 7 concerned is granted, the identity of the requester or, as the case may be, the consent of the individual is established to the satisfaction of the head.

(3) Where a request under section 7 relates to—

(a) a record of a medical or psychiatric nature relating to the requester concerned, or

(b) a record kept for the purposes of, or obtained in the course of the carrying out of, social work in relation to the requester,

and, in the opinion of the head concerned, disclosure of the information concerned to the requester might be prejudicial to his or her physical or mental health, well-being or emotional condition, the head may decide to refuse to grant the request.

(4) Where, pursuant to subsection (3), a head refuses to grant a request under section 7—

(a) there shall be included in the notice under section 8 (1) in relation to the matter a statement to the effect that, if the requester requests the head to do so, the head will offer access to the record concerned, and keep it available for that purpose, in accordance with section 8 (3) to such health professional having expertise in relation to the subject-matter of the record as the requester may specify, and

(b) if the requester so requests the head, he or she shall offer access to the record to such health professional as aforesaid, and keep it available for that purpose, in accordance with section 8 (3).

(5) Where, as respects a request under section 7 the grant of which would, but for this subsection, fall to be refused under subsection (1), in the opinion of the head concerned, on balance—

(a) the public interest that the request should be granted outweighs the public interest that the right to privacy of the individual to whom the information relates should be upheld, or

(b) the grant of the request would benefit the individual aforesaid,

the head may, subject to section 29, grant the request.

(5A) Where—

(a) a request under section 7 relates to a record to which subsection (1) applies but to which subsections (2) and (5) do not apply or would not, if the record existed, apply, and

(b) in the opinion of the head concerned the disclosure of the existence or non-existence of the record would have the effect specified in subsection (1),

he or she shall refuse to grant the request and shall not disclose to the requester concerned whether or not the record exists.

(5B) Notwithstanding paragraph (a) of subsection (2), a head shall, subject to paragraphs (b) to (e) of that subsection and subsections (5) and (6), refuse to grant a request under section 7 if, in the opinion of the head, access to the record concerned would, in addition to involving the disclosure of personal information relating to the requester, also involve the disclosure of personal information relating to an individual or individuals other than the requester.¹⁰

(6) Notwithstanding subsection (1), the Minister may provide by regulations for the grant of a request under section 7 where —

(a) the individual to whom the record concerned relates belongs to a class specified in the regulations and the requester concerned is the parent or guardian of the individual, or

(b) the individual to whom the record concerned relates is dead and the requester concerned is a member of a class specified in the regulations.

(7) In this section ‘health professional’ means a medical practitioner, within the meaning of the Medical Practitioners Act, 1978, a registered dentist, within the meaning of the Dentists Act, 1985, or a member of any other class of health worker or social worker standing prescribed, after consultation with such (if any) other Ministers of the Government as the Minister considers appropriate.”

8. Section 41 of the 1997 Act concerned decisions deemed to have been made in certain cases. It stated:

¹⁰ Sub-sections 28(5A) and (5B) were inserted by s. 23 of the Freedom of Information (Amendment) Act 2003 and were commenced on enactment.

“41.—(1) Where notice of a decision under section 8 or 17 is not given to the requester concerned or to the person who made the application concerned under section 17 before the expiration of the period specified for that purpose in section 8 or 17, as the case may be, a decision refusing to grant the request under section 7 or the application under section 17 shall be deemed for the purposes of this Act to have been made upon such expiration and to have been made by a person to whom the relevant functions stood delegated under section 4.

(2) Where notice of a decision under section 14 is not given to the person who made the application concerned under that section before the expiration of the period specified in subsection (4) thereof, a decision affirming the decision to which the application relates shall be deemed for the purposes of this Act to have been made upon such expiration.

(3) Where a statement under subsection (1), or notice of a decision under subsection (4), of section 18 is not given to the person who made the application under the said subsection (1) concerned before the expiration of the period specified for that purpose in the said subsection (1) or (4), as the case may be, a decision refusing to grant the application shall be deemed for the purposes of this Act to have been made upon such expiration and to have been made by a person to whom the relevant functions stood delegated under section 4.”

Commission of Investigation
(Certain matters relative to a disability service in
the South East and related matters)
("the Farrelly Commission")
Commission of Investigation statement on Part
X of the Terms of Reference

Published 15 April 2025

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PART X STATEMENT

1. Preliminary

1.1 The Commission's consideration of Part X of its Terms of Reference is set out in this Statement.

1.2 Part X of the Terms of Reference states as follows:

*“Report on Review of Certain Matters Relating to a Disability Service in the South East”
by Conor Dignam SC*

Having regard to the facts established through the investigations at Part III to IX above, specify the scope of the further investigations (phase two) which the Commission will undertake in the public interest having regard to the facts established and information in its possession including the report by Conor Dignam SC in his Review of Certain Matters Relating to a Disability Service in the South East (29th August 2016) and his recommendations regarding the areas to be examined by a Commission of Investigation contained in Chapter 4 of that report. For the avoidance of doubt, this includes recommendations of the Dignam report concerning Care and Decision Making in respect of Others, Actions of the HSE in terms of investigating/protecting others and Protected Disclosures including the HSE's treatment of “whistleblowers” contained on pages 306 to 308.”

1.3 Before setting out the Commission's considerations in respect of Part X, it is important to state the following.

1.4 It should be noted at the outset that while Part X is expressed in the above terms, the Commission considers that the question of what (if any) further matters should be investigated by it, following delivery of its Final Substantive Report of 26th July, 2024 on the outcome of the Phase One investigations, is ultimately a matter to be determined by the Government. It is important that the Commission's reports on the outcome of all investigations in Phase One, the facts reported, and the findings made on the extensive Terms of Reference set for those investigations, are considered in full, so as to assist in determining the question of the extent of any such further investigations required.

- 1.5 In that regard, the issue of what the Government may consider to be matters of significant public concern that remain to be investigated in the public interest, and the setting of the scope and Terms of Reference with respect to such matters as provided for under the Commissions of Investigation Act, 2004 (“the Act of 2004”), are functions of Government.
- 1.6 This Statement with respect to the Commission’s consideration of Part X and the recommendations as set out below should assist the Minister and the Government in this determination.
- 1.7 The Commission is mindful of the fact that, prior to its establishment and the setting of its Terms of Reference in Phase One, the Minister and the Government have had the reports listed at Part II. e) of the Terms of Reference together with the Protected Disclosures which are referred to in the *Dignam Report*.
- 1.8 For ease of reference, those reports are listed as follows:
1. the report of Conal Devine & Associates Inquiry into Protected Disclosures, SU1 (2012);
 2. the report of Resilience Ireland Ltd. Disability Foster Care Report HSE South East (2015);
 3. the reports prepared by Resilience Ireland on behalf of the HSE, and referenced on page 186 of the *Dignam Report (Report of Conor Dignam SC Review of Certain Matters relating to a Disability Service in the South-East (2016))*:
 - i. the report on the HSE Response on receiving the Conal Devine Report in 2012;
 - ii. the report on the HSE and Garda engagement in all of these matters; and
 - iii. the report on the appeal by Foster Family X on the proposed transfer of the service user placed long term in this placement to residential care.

4. The report of Conor Dignam SC Review of Certain Matters relating to a Disability Service in the South-East (2016).

1.9 For ease of reference, the relevant Protected Disclosures are listed as follows:

- 20th November, 2009: Ms B and Ms D to HSE (referred to as Ms D and Ms E in the *Dignam Report*);
- 26th November, 2009: Ms B and Ms D to HSE;
- 14th December, 2009 and 1st March, 2010: Mr. Iain Smith, HSE Social Work Team Leader to HSE; and
- 30th September, 2014: Mr. Smith to the Minister for Health.

1.10 The Commission does not intend to refer to the detail of those documents for the purposes of the matters set out by it in this Statement. The Commission is, however, mindful that there may be issues that remain as matters of significant public concern for the Minister and the Government related to these documents, on consideration of the matters set out below, or following consideration of the Commission's Substantive Reports.

1.11 The Commission is therefore satisfied that the appropriate manner in which to carry out the task set for it by Part X is to provide certain information to the Minister and to make certain recommendations, as set out below.

2. Consideration of the Dignam Recommendations

2.1 The Commission has had regard to the facts established through the investigations at Parts III to IX of the Terms of Reference, information in its possession, and the extensive recommendations listed in Chapter 4 of the *Dignam Report*. The Commission considers that the most appropriate manner in which to address Part X matters is to do so by reference to that list of recommendations.

2.2 Chapter 4 of the *Dignam Report*, which is attached hereto for ease of reference, made recommendations in relation to the then proposed Commission under various

headings. It should be noted that these headings, which are addressed immediately below, are in a different sequence to the manner in which they are listed in that chapter.

The establishment and monitoring of the foster placement

- 2.3 The matters referred to under this heading have already been investigated under the Commission's Terms of Reference set for Phase One. The facts established by the Commission's investigations into these matters have been reported in the First Substantive Interim Report dated 11th January, 2021, the Second Substantive Interim Report dated 31st March, 2021 and in the Commission's Final Substantive Report dated 26th July, 2024.

Care and Decision Making in respect of Grace

- 2.4 With respect to the recommendations under the heading *Care and Decision Making in respect of Grace*, the matters referred to have been investigated under the Commission's Terms of Reference set for Phase One. The facts established by the Commission's investigations into these matters have already been reported in the First and Second Substantive Interim Reports, and in the Final Substantive Report.

Allegations of cover up

- 2.5 The recommendations under this heading were as follows:

- *whether there was any deliberate suppression or attempted suppression of information during any of the period 1996-2016 with particular reference to the period from July, 2009 to March, 2016 in relation to Grace's case, including, but not limited to, an alleged danger of deliberate destruction of files or alleged threats by the HSE to the funding of the Agency whose staff made Protected Disclosures. This Review and Report should not be taken as precluding a re-examination of any of the issues which this Review has already examined. The Commission of Inquiry will have the benefit of, inter alia, viva voce evidence and cross-examination; and*
- *fully investigate all matters contained in complaints by two of the Protected Disclosers to the Department of Health in 2014.*

- 2.6 The first recommendation relates to the question of whether there was any deliberate or attempted suppression of information in relation to Grace's case during any of the period 1996-2016, with particular reference to the period from July, 2009 to March, 2016, including, but not limited to, an alleged danger of files or alleged threats by the HSE to the funding of the Agency whose staff made Protected Disclosures.
- 2.7 These issues came within the Commission's Terms of Reference in Phase One. Volumes 1 and 2 of the Final Substantive Report extensively report upon the facts established by the Commission on foot of its investigations into all aspects of the management of Grace's case from July, 2007 onwards and set out its findings into alleged matters of cover-up or suppression of information or matters of that nature.
- 2.8 The second recommendation is that all matters contained in complaints by two of the Protected Disclosers to the Department of Health in 2014, be fully investigated.
- 2.9 The Commission notes the content of the letter of 30th September, 2014 from Mr. Smith to the Minister for Health under s. 8 of the Protected Disclosures Act, 2014, together with Mr. Smith's File Review Report on "*Adults with Intellectual Disabilities linked to the Waterford Disability Services*" dated 7th August, 2013 reporting on the outcome of a substantial File Review Project commenced in 2011. This was stated to be a review of over 1000 adult clients known to the disability services in the Waterford Local Health Area and contained detailed recommendations arising from that review.
- 2.10 Bearing in mind the heading for these recommendations, the Commission does not have information in its possession with regard to any specific allegations of cover-up, suppression or attempted suppression of information having been made in 2014, over and above the allegations already referred to above, and the Commission is not clear as to what is referred to under this heading.
- 2.11 There were issues raised by the Protected Disclosers, Ms B and Mr. Smith, concerning the nature of the reviews and investigations which gave rise to the reports referred to at Part II. e) in the Terms of Reference.
- 2.12 These issues led to the commissioning of the *Dignam Review* by the Minister for Social Affairs. That review was charged with "*examining the processes which were applied*

by the HSE in procuring the services of the firms engaged to provide such reports, the adequacy and appropriateness of the approach adopted and of the reviews contained in the Reports, whether the reasons for those Reports not being published by the HSE are well grounded, and whether, having regard to a number of factors, the Reports can be published.”

2.13 The Terms of Reference for the *Dignam Review* are set out at paragraph 1.3 of the *Dignam Report*, which has reported upon such matters.

2.14 The Commission does not have information in its possession that would indicate that further examination is required into those investigations which were commissioned by the HSE and undertaken prior to its establishment.

Protected Disclosures

2.15 The recommendations in relation to matters for investigation under the heading *Protected Disclosures* refer to both the treatment of the Protected Disclosures themselves and the treatment by the HSE of those who made the Protected Disclosures, as follows:

- *the facts relating to the HSE’s treatment of the Protected Disclosures made in respect of the foster placement and related issues, and any failings and/or omissions in relation to the way in which they were treated;*
- *the facts relating to the treatment by the HSE of those who made the Protected Disclosures in respect of the foster placement and related issues; and*
- *the facts relating to the sharing of information by the HSE with any relevant individuals or agencies with particular reference to Ms. D (referred to in the Commission’s Final Substantive Report as Ms B).*

2.16 The reports which referred to matters raised in the Protected Disclosures are set out in the Commission’s Terms of Reference at Part II. e).

2.17 With regard to the HSE’s treatment of the Protected Disclosures, a certain amount of information has been reported in the Final Substantive Report about the HSE’s receipt or knowledge of the Protected Disclosures, and communication between the HSE at a

local and national level with regard to the management of Grace's case in the period after the HSE became aware of the Protected Disclosures by Ms B and Ms D in November, 2009.

- 2.18 The reports referred to above, commissioned by the HSE to inquire into certain matters referred to in the Protected Disclosures, together with the *Dignam Review*, provide information on the manner of the HSE's response to the making of the Protected Disclosures, *i.e.* with regard to the background to the commissioning of those reports.
- 2.19 The Commission therefore notes that there is substantial information already available to the Minister concerning the manner in which the Protected Disclosures themselves were treated by the HSE.
- 2.20 The Commission does not have additional information in its possession arising from its investigations, with respect to failures or omissions in relation to the way in which the Protected Disclosures that were made were treated.
- 2.21 While it is a matter for the Government ultimately to be satisfied as to whether there are matters of significant public concern that require further investigation of this topic, the Commission is of the view that an investigation at this stage on how the Protected Disclosures were treated is unlikely to lead to the establishment of facts that would significantly add to the information already in the possession of the Minister from the reports to date, as to merit embarking on such an investigation.
- 2.22 Although this is a different issue to that of the treatment by the HSE of the Protected Disclosures themselves, it should be noted that the concerns raised in the Protected Disclosures as they related to Grace's case and issues about the conduct of public bodies in the course of managing her case have been investigated by the Commission. The Commission's findings are reported upon, where relevant, in the Commission's Substantive Reports.

Treatment of persons who made Protected Disclosures

- 2.23 As set out above, Protected Disclosures were made by Mr. Smith and also by Ms B and Ms D jointly.

- 2.24 With respect to the treatment by the HSE of persons who made Protected Disclosures, the interactions between HSE personnel and Ms B, Ms D, and Day Service Provider A in connection with Grace's case from late 2007/early 2008 to in or about December, 2012 are reported in detail throughout Volumes 1 and 2 of the Commission's Final Substantive Report. This included their interactions in Grace's case from November, 2009 onwards, when the HSE first became aware of the fact that Ms B and Ms D had made a Protected Disclosure and of its content.
- 2.25 The Commission does not have further information in its possession about the HSE's treatment of Ms B or Ms D which suggests that further inquiries may need to be undertaken in this matter. Based on the facts established and already reported in Volumes 1 and 2, the Commission considers it to be unlikely that further investigation into the question of the treatment of Ms B and Ms D by the HSE would provide any significant further information on this topic, as to merit embarking on such further investigation.
- 2.26 With respect to the treatment by the HSE of Mr. Smith, who made his Protected Disclosures on 14th December, 2009 and on 13th September, 2014, Mr. Smith's role in Grace's case from August, 2007 onwards is reported upon in detail in the Final Substantive Report. This includes reporting on facts that related to the treatment of Mr. Smith in that role and his interactions with personnel in the HSE in the course of the HSE's management of Grace's case beyond the time when Mr. Smith made his Protected Disclosure on 14th December, 2009.
- 2.27 While the treatment of Protected Disclosers was not a matter for investigation within the Commission's Terms of Reference in Phase One, the Commission considers that the matters reported with respect to issues regarding the management of Grace's case, also provide some information about the treatment by the HSE of Mr. Smith following the making of this Protected Disclosure.
- 2.28 As noted above, the issues of concern raised by Mr. Smith with regard to matters to do with the commissioning by the HSE of the reviews/reports referred to above were addressed in the *Dignam Report*.
- 2.29 The Commission notes that Mr. Smith raised concerns with regard to his treatment by the HSE in his letter by way of Protected Disclosure dated 30th September, 2014 to the Minister for Health. These were set out in the letter and summarised at page 12 thereof.

With regard to the question of his treatment, Mr. Smith alleged that the HSE had threatened him with disciplinary proceedings; however, he stated that this related to his concerns about handing over confidential files *via* his office (when he was instructed to do so) to the company engaged by the HSE to investigate some of the concerns raised by him. The basis of Mr. Smith's concerns about handing over such files were referred to in this Protected Disclosure letter.

- 2.30 The Commission has no information in its possession that the HSE took disciplinary proceedings against Mr. Smith in connection with the above and is not aware of any such proceedings having been initiated. Mr. Smith left his employment with the HSE in 2015 and it has been widely reported in the public domain that this was due to his frustration and concerns (reflected in his letter of 30th September, 2014), which may be summarised in broad terms as relating to the manner in which Grace's case had been managed within the HSE, and to his dissatisfaction with how his concerns about services and his Protected Disclosures had been addressed by the HSE, including in relation to the commissioning by the HSE of the reports referred to above.
- 2.31 The Commission does not have further information in its possession arising from its investigations in Phase One with respect to the HSE's treatment of Mr. Smith, a person who made Protected Disclosures, that identifies further events or areas for investigation into that treatment by the HSE, arising from the making of Protected Disclosures by him.
- 2.32 While ultimately a matter for the Minister and the Government, the Commission is of the view that an investigation at this stage into how Mr. Smith was treated by the HSE as a result of having made Protected Disclosures, is unlikely to lead to the establishment of facts that would significantly add to the facts as already reported, as to merit embarking on such an investigation.
- 2.33 With regard to the recommendation of the *Dignam Report* under this heading to investigate the facts relating to the sharing of information by the HSE with any relevant individuals or agencies, with particular reference to Ms B, the issue of the sharing of information by the HSE, including with reference to Ms B, has been fully reported under the Commission's Terms of Reference in Phase One, in particular in Volumes 1 and 2 of the Final Substantive Report.

The cases of other service users

- 2.34 The recommendations of the *Dignam Report* with respect to other persons who stayed in the Family X placement, to which the Commission is to have regard for the purposes of Part X of the Terms of Reference, are set out under the headings “*Care and Decision Making in Respect of Others*” and “*Actions of the HSE in terms of investigating/protecting others*”.
- 2.35 The matters encompassed in the recommendations as to what a Commission might be asked to inquire into under these headings cover a very wide range of potential areas for investigation. These are set out as follows.

Care and Decision Making in respect of Others

- *Investigate all matters referred to in the Protected Disclosures of the 20th November 2009, 26th November, 2009 and 1st March, 2010 in addition to the care and service delivery issues relating to Grace insofar as they deal with the acts or omissions on the part of the public bodies and their employees or publicly-funded voluntary agencies and their employees.*
- *The facts surrounding the care received by all persons placed at the said foster placement, including whether any of them suffered abuse during the placement and, if so, whether the HSE or the SEHB knew of same or ought to have known of same.*
- *The facts surrounding any decisions made by the HSE or service providers in relation to each and every service user's use of the foster placement or respite placement*
- *Whether the HSE should have known of another person's continued use of this placement between November, 2009 and April, 2010 and, if not, how it was that they were not aware of it.*
- *The facts in relation to all steps taken by the HSE in relation to that person's continued use of the placement.*
- *The details of all interactions between HSE staff members and the former foster mother in relation to any service user, any person using the placement on a private arrangement basis, the fact of allegations having been made or the HSE*

having concerns about the placement, the establishment and existence of the Devine Inquiry and the appropriateness of those interactions.

- *Any failures/omissions on the part of the HSE or any party in respect of the foster placement.*

2.36 In having regard to the above recommendations for the purposes of Part X of the Terms of Reference, the Commission has focused on the facts already established and reported upon in Phase One, together with the information in its possession with respect to the other persons who spent time in the Family X placement. In particular, the Commission has focused upon the cases of the persons by or on behalf of whom allegations of abuse have been made against Mr. X and/or Mrs. X.

2.37 The Commission notes that the issues listed to be considered for investigation under the heading of “*Care and Decision Making in respect of Others*” broadly focus on the role or conduct of public bodies or agencies, with specific reference to the SEHB’s and HSE’s potential role in those cases. The recommendation for investigation of the facts surrounding the care received by all persons placed at the said foster placement, including whether any of them suffered abuse during the placement, includes a reference to inquiry into “*if so, whether the HSE or the SEHB knew of same or ought to have known of same.*”

2.38 With respect to the reference above to “*another person’s continued use of this placement between November, 2009 and April, 2010...*” the Commission understands that this refers to the person referred to by the initials Q.Q. in Volume 3 of the Commission’s Final Substantive Report. In that Volume, the Commission has reported upon the evidence it received from that person’s parents of her continued use of the placement (up to in or about 2013) and on the fact that there were no allegations made with respect to that person’s care relating to her time in the placement. Insofar as the recommendations refer to inquiring about the HSE’s interactions with the former foster mother, it should be noted that Mrs. X is now deceased. The above recommendation relates to a question as to whether information about the fact that there were concerns or allegations in connection with the placement was shared by the HSE with the families of any other service users or persons there on a private placement. In light of the matters reported, the Commission does not consider that an investigation into what this person’s parents were/were not told with regard to the existence of other

allegations will greatly add to the facts and information already reported on following the evidence obtained in the course of Phase One.

- 2.39 From the information that came into the Commission's possession in the course of its investigations, there were 47 persons (service users) other than Grace, who were identified to the Commission as persons who spent time in the Family X placement, on differing dates between 1983 and 1993 (with Q.Q. having stayed there for periods of time up to 2013).
- 2.40 This figure includes persons who came to the placement by availing of the Holiday Placement Scheme (reported upon in the Commission's Phase One reports) or through private arrangement.
- 2.41 The Commission was provided with substantial material containing information with respect to the above placements. This included (but was not limited to) materials such as the Boarding Out records kept by the SEHB; Garda investigation materials including statements taken in the course of such investigations; questionnaires and responses; records of interviews with service users and/or their family members, Mrs. X, members of the Family X household and a variety of other persons contacted in the course of An Garda Síochána investigations into any allegations made concerning the placement and in particular Mr. X and/or Mrs. X; the recommendations arising from the Garda investigations into the cases of other service users; together with the directions of the Director of Public Prosecutions (D.P.P.) in each case. The Commission also had the reports set out at Part II. e) of the Terms of Reference.
- 2.42 The Commission has identified seven persons from that number of 47 persons, by or on behalf of whom allegations of abuse (within the definition provided at Part XI. of the Terms of Reference) have been made against Mr. X and/or Mrs. X, or concerns reported in connection with their stay at the placement.¹ Allegations of abuse were made in respect of five of them and concerns were raised in respect of two. These

¹ One of the 47 service users who has not been included in the 7 people identified stayed in the placement at times in 1986 and 1988 when he was between six and eight years of age. In the course of the Garda investigations into the placement in 2014, it was reported that this individual had regressed significantly over a two year period from 1986 to 1988 on return from the placement, with behavioural changes including agitation, incontinence, and sleep disturbance. There are no direct allegations of abuse with respect to his treatment at the placement and this case is not listed for potential investigation as the basis for establishing a nexus or otherwise between his stay in the placement and the behavioural changes outlined would, particularly at this remove, appear to be lacking.

include a number of serious and concerning matters. A broad outline of these allegations/concerns is set out in the appendix below.

- 2.43 Further and more detailed information with regard to each case can be provided to the Minister if required.
- 2.44 From the information in the possession of the Commission, there were no allegations or complaints made by or on behalf of 39 of those service users who had stayed in the placement and positive experiences were noted to have been reported in the case of some of these persons.
- 2.45 There were no prosecutions recommended by An Garda Síochána or directed to be taken by the D.P.P. in the case of any of the 47 service users.

Actions of the HSE in terms of investigating/protecting others

- 2.46 The recommendations under the heading *“Actions of the HSE in terms of investigating/protecting others”* are as follows:
- *the facts relating to any difficulties in the functioning of the relevant social work department, including any reasons underlying such difficulties;*
 - *the facts relating to any steps that were taken to address these difficulties, the question of whether any such difficulties had any impact on the care and welfare of service users and, if they had such impact, how that situation was permitted to arise; and*
 - *the facts relating to the care received by all of those placed in the foster placement.*
- 2.47 With respect to the first two recommendations, it should be noted that the functioning of the Social Work Department in Waterford Community Services has been reported upon by the Commission in Phase One in the context of reporting upon the management of Grace’s case. This has included reporting on matters such as the role and functioning of the Vulnerable Adults Committee (VAC), that of disability services within the HSE, of social workers and managers, and upon issues with regard to supervision of HSE employees.

- 2.48 The Commission did not embark upon investigations with respect to workplace relations issues, save insofar as these were considered directly relevant to the establishment of the facts with regard to decision-making and actions/inaction in Grace's case.
- 2.49 The above recommendations relate to "*investigating/protecting others*". Should the question of the functioning of the relevant Social Work Department arise for consideration in the context of the placement of the persons referred to below, it is at least possible that this could be relevant to the scope of any inquiry to establish the facts with regard to those particular placements. However, the Commission does not have information in its possession that identifies specific difficulties with the functioning of the Social Work Department in the cases where there were subsequent allegations, as referred to in the appendix.
- 2.50 As noted earlier in this Statement, broader concerns raised by Mr. Smith about service provision in his File Review Report dated 7th August, 2013, together with his Protected Disclosures, are known to the Minister. The Commission does not have further information in its possession through its investigations with regard to these broader issues or the circumstances of cases, entirely unrelated to the Family X placement.
- 2.51 The question of whether these matters raise significant public concern or warrant being the subject of an official investigation is a matter for the Minister and the Government.

3. Matter of further investigations

- 3.1 From the information in the Commission's possession, the Commission does not consider that the cases of 40 of the 47 service users who stayed in the Family X placement at various stages, and in respect of whom no allegations were made with respect to the placement, require to be investigated in a second phase of the Commission's work.
- 3.2 The Commission considers that the seven cases in which allegations have been made or concerns raised should potentially be investigated further. However, the appropriate mechanism for so doing may not be a Commission of Investigation. The Z.Z. case (referred to further below) may be distinguished from the other six cases in that regard as substantial evidence, including the testimony of Mrs. X, was taken during the course of the investigations in Phase One into the SEHB's investigation of aspects of this case

in 1992/1993, as reported in Volume 5 of the Final Substantive Report. How the HSE considered other aspects of the Z.Z. case is reported on in Volume 1 of the Final Substantive Report.

- 3.3 The observation that the appropriate mechanism of inquiry may not be a Commission of Investigation is based on evidentiary considerations, and also upon the type of issues that may fall to be investigated in these cases, particularly the extent of any involvement of the public authorities in these cases.

Evidentiary considerations

- 3.4 The Commission's investigations in Phase One have been extensive, thorough and evidence-based in accordance with the provisions of the Act of 2004. The Commission heard evidence on 251 days. All of the evidence received by the Commission was carefully analysed, balanced and considered in establishing the facts as reported in the Commission's Phase One reports on Grace's case.
- 3.5 In specifying the cases of the other seven service users by or on whose behalf allegations or complaints have been made or concerns raised, the Commission notes that evidence from certain persons will be unavailable as they are deceased. Mr. X and Mrs. X, in whose care the service users referred to above were placed, passed away in 2001 and 2024 respectively. E.E., by and on behalf of whom serious allegations concerning sexual abuse were made in 1996 and in the course of Garda investigations in 2014, passed away in December, 2016, prior to the establishment of the Commission.
- 3.6 The Commission's examination of Mrs. X in Phase One concluded before her death. She fully engaged with the Commission and gave significant evidence over 14 days with respect to the matters under investigation in Phase One. It is apparent to the Commission from the documentation available to it that, in the course of the Garda investigations into the placement, she denied and refuted the allegations made on behalf of six of the service users identified by the Commission for possible investigation².

² It should be noted that no specific allegations were made to the Gardai in respect of K.K. and therefore no such allegations were raised with Mrs. X in the course of the Garda investigations referred to in the Appendix.

- 3.7 The fact that Mr. X was deceased by the time the Commission was established did not impede the conduct by the Commission of a thorough Phase One investigation, including in relation to the manner in which the SEHB addressed the allegations made on behalf of Z.Z. and E.E. in 1992/93 and 1996 respectively. The Commission's inability to examine Mr. X in relation to the aspects of those cases that fell to be considered under the Phase One Terms of Reference was, to some extent, offset by the assistance which the Commission derived from Mrs. X's participation in its investigations.
- 3.8 Any Phase Two investigation into the allegations and concerns arising in respect of the seven service users would differ materially from the Phase One investigation given that Mrs. X is now unavailable as a witness. The potential implications for the fairness and completeness of any further investigation of the allegations and concerns arising in respect of these service users in the absence of both Mr. and Mrs. X is an important factor (but not the only factor) to be borne in mind in deciding upon the nature and extent of any inquiry that may be conducted.
- 3.9 With that in mind, the Commission notes the provisions of s. 32(1) and (2) of the Act of 2004 which state:

(1) On the conclusion of its investigation, a commission shall prepare a written report, based on the evidence received by it, setting out the facts it established in relation to the matters referred to it for investigation.

(2) If for any reason (including insufficient, conflicting or inconsistent evidence) a commission considers that the facts relating to a particular issue have not been established, the commission in its report—

(a) shall identify the issue, and

(b) may indicate its opinion as to the quality and weight of any evidence relating to the issue.

- 3.10 In accordance with the above, a Commission of Investigation is required to prepare an evidence-based written report setting out the facts established from its investigation. While s. 32(2) sets out the procedure to be adopted where there are evidential deficits, it is appropriate in the context of Part X to identify from the outset that there will be an absence of certain key evidence affecting the ability of the Commission to conduct and,

importantly, to conclude an investigation leading to the clear establishment of facts with respect to allegations made or concerns raised.

- 3.11 The allegations made in the above cases relate to events alleged to have occurred between 1983 and 1993. While evidential difficulties associated with the passage of time and the absence of records will inevitably arise, these factors alone do not preclude inquiry into these allegations.
- 3.12 The Commission does not consider that it is appropriate to make any comment on the potential strength or frailties of the evidence based on a documentary review of the information in its possession.

The role of public authorities

- 3.13 The Commission is mindful that it was the role and conduct of public bodies in Grace's case and the concerns and allegations raised in the Protected Disclosures, including those of alleged mismanagement, suppression, cover-up, threats to funding, destruction of files, potential political interference and also treatment of Protected Disclosers that came to the fore with respect to the management of her case. These were clearly considered to be matters of significant public concern, which gave rise to the establishment of the Commission of Investigation and to the Terms of Reference set for the Commission's Phase One inquiries, relating specifically to Grace's case.
- 3.14 The cases of other service users did not form part of the Commission's inquiries mandated pursuant to the Terms of Reference set for Phase One. The exception to this position, insofar as the Commission's Phase One investigations were concerned, related to the role of public authorities in the cases of E.E and Z.Z., referred to in the appendix.
- 3.15 This was primarily necessitated by Term of Reference IV. d), which required the Commission to establish the facts relating to the treatment and investigation by the SEHB, any other Health Board or the HSE of any allegations made in respect of Family X and communicated to any Health Board or the HSE by any party whatsoever, as referred to in the *Devine Report*.
- 3.16 This Term of Reference required the Commission to investigate the way in which the allegations that were made on behalf of E.E. in 1996 and Z.Z. in 1992 were treated

and investigated by the SEHB. Those investigations were limited to the requirements of the Term of Reference and to the impact, if any, of the SEHB's treatment and/or investigation of those allegations on the management of Grace's case, bearing in mind that the Phase One investigations were specifically limited to her case.

- 3.17 In the above regard, the Commission's First Substantive Interim Report has reported upon the nature of the allegations that were made on behalf of E.E. in the year 1996 and communicated to the SEHB and the manner in which they were addressed in the context of Grace's case at that time.
- 3.18 Volume 5 of the Final Substantive Report reports upon the nature of the allegations made on behalf of Z.Z. in 1992 and the manner in which these were investigated by the SEHB at the time.
- 3.19 Thus, the role of the relevant public authority has already been reported in those two cases and is not a matter requiring further investigation.
- 3.20 From the information in its possession with respect to the cases of G.G., Y.Y., H.H., L.L. and K.K., the Commission does not have information of any specific allegations having been made about the conduct of public authorities or their employees or officials in relation to these cases, akin to the type of concerns that were raised with respect to Grace's case. The Commission has minimal information of there having been any public body involvement in these cases, save that certain placements were under the umbrella of the Holiday Placement Scheme, the operation of which has been reported upon in Phase One.
- 3.21 The information in the possession of the Commission about when these allegations or concerns first came to the attention of the HSE or An Garda Síochána is set out in the appendix below. It does not appear from the information in the possession of the Commission that the SEHB (as predecessor to the HSE) was aware of these allegations at the time of the alleged events or until some years later. At the time G.G., Y.Y., H.H., L.L. and K.K. were in the placement with Family X, the allegations in the cases of Z.Z. and E.E. had not yet been made.

4. Conclusion

- 4.1 The Commission considers that there is an expectation that persons by or on behalf of whom serious allegations have been made against Mr. X and/or Mrs. X with respect to their stay in the Family X placement will have their cases examined following the conclusion of Phase One of the Commission's investigations into Grace's case, having regard to the structure of the Terms of Reference and the provisions of Part X.
- 4.2 The absence of information in the possession of the Commission, indicating issues for investigation with respect to matters to do with the role or conduct of public authorities in these cases (save for the cases of E.E. and Z.Z., where the role of public authorities has already been investigated and reported upon by the Commission) has been identified in this Statement. This is in no way to minimise the importance of the allegations themselves or of the concerns raised but is simply to highlight what might or might not be viewed as public interest requirements for the purpose of considering whether further inquiry should be conducted by a Commission. The extent, however, to which this may influence the manner of inquiry that might be undertaken is ultimately a matter for the Minister and the Government.
- 4.3 The Commission considers that the experiences and accounts of these seven service users in the placement should be heard and inquired into to the extent that this can be done. The Commission is of the view that some consultation with the identified service users (and/or their families as appropriate) may be helpful in determining what level of further investigation may be required. Having regard to the matters set out above, it is recommended that consideration be given by the Minister and the Government to the question of whether this would be best achieved through the mechanism of an investigation under the Act of 2004 in a Phase Two set of investigations, or whether a different mechanism of inquiry into these cases should be explored at this stage.

Marjorie Farrelly, Senior Counsel
Sole Member

Dated this 29th day of July, 2024

Appendix

Confidential Information

Introduction

- 1.1 It is important to highlight that the matters set out below with respect to the nature and circumstances of the allegations that have been made in these cases, based on the information in the possession of the Commission, are by way of broad outline only and should not be taken to convey all of the salient information or detail that is relevant to these cases.
- 1.2 The Commission can, however, provide further detail with respect to these cases and the allegations made or concerns raised, as may be required by the Minister.
- 1.3 In reporting the outcome of Garda investigations, the Commission is mindful that different considerations may apply in that process.
- 1.4 In considering public authority issues below, the Commission refers to whether there are specific issues or allegations, such as existed in Grace's case, that may merit investigation by a Commission concerning the role or conduct of public authorities into the particular person's use of the placement.
- 1.5 The Commission has reported upon the setting up of the Holiday Placement Scheme, the role of the Brothers of Charity and the SEHB in the Scheme and on how it operated and came to an end in its Phase One Reports. It may be noted that the Commission does not have information in its possession through its Phase One investigations into Grace's case relating to any inspections or monitoring of the placements forming part of the Scheme, apart from the information about the Scheme that has been reported.

Case 1 – G.G.

Dates and/or duration of placement: Approximately December, 1983 – May, 1984.

Type of placement: Private.

Age at time of placement: 4 and a half years of age.

Disability issues: No disability.

Nature of allegations: Physical abuse and mistreatment by Mrs. X. Allegations of slapping, shouting, aggression, being locked in a dark room, being given a small bottle of Guinness before bed.

When reported to the authorities: Statement made by G.G. to An Garda Síochána in October, 2017.

Response to allegation: Mrs. X interviewed by An Garda Síochána. All aspects of the allegations made were denied in full.

Outcome of Garda investigations: No prosecution recommended. The reasons for this are set out in the Garda report which will be available for any further investigations.

Public authority issues: No indication of any SEHB/public authority involvement in arrangement of placement. From the information in the possession of the Commission, there are no allegations with respect to the conduct of public authorities in connection with G.G.'s placement for investigation in this case.

Case 2 – E.E. (deceased)

Aspects of this case have already been extensively reported upon by the Commission in Phase One having regard to the Terms of Reference set in Grace's case, which included inquiry into the manner in which the allegations made in this case were managed or addressed by the SEHB in 1996.

The First Substantive Interim Report has reported in detail on the nature of the allegations of sexual molestation and abuse by Mr. X made on behalf of E.E. in 1996 and notified to the SEHB at that time, and on the matters investigated by the Commission under the Terms of Reference in Phase One with respect to the management of Grace's case in the light of those allegations having been made.

Dates and/or duration of placement: 3rd July, 1984 and 26th July, 1987, lasting for a week on each occasion.

Type of placement: Holiday Placement Scheme.

Age at time of placement: 10 years of age/13 years of age.

Disability issues: Yes.

Nature of allegations: The allegations of sexual abuse and molestation that were made on E.E.'s behalf in 1996 and notified to the SEHB are reported in the First Substantive Interim Report.

In 2014, during the course of the Garda investigations into the placement, the police in England interviewed E.E. on one occasion through specialist interviewers. The interview with E.E. expanded on the allegations of sexual abuse made on her behalf in 1996 by making further allegations of sexual abuse and it was alleged in her interview that Mrs. X was aware of and complicit in Mr. X's abuse of her. E.E.'s mother also made a statement in 2014.

When reported to the authorities: See above.

Response to allegations: Mrs. X was interviewed by An Garda Síochána and she denied in full all of the allegations made by E.E.

Outcome of Garda investigations: No prosecution recommended. The reasons for this are set out in the Garda report which will be available for any further investigations.

Public authority issues: As noted above, the manner in which the information notified to the SEHB in 1996 concerning allegations on E.E.'s behalf was addressed by the SEHB and An Garda Síochána has been reported upon in the First Substantive Interim Report.

Note: The Commission was advised that E.E. had subsequently passed away in December, 2016, before the Commission was established.

Case 3 – K.K.

Dates and/or duration of placement: Late 1980s for two weeks initially and for periods in the summers of 1986, 1988, 1989, and 1990.

Type of placement: Private placement and Holiday Placement Scheme.

Age at time of placement: Approximately 11 years of age to 17 years of age.

Disability issues: Yes.

Nature of concerns: K.K.'s mother recounted incidents towards the end of K.K.'s time in the placement of when K.K. appeared to be shaking, nervous and frightened when Mr. X came to collect her. She did not know the reason for this behaviour. She recounted that K.K. was not dressed properly, not washed, with clothes on backwards when she came back after her next visit. In that regard, K.K.'s mother recounted that this presentation began to happen as Mrs. X took on more children and she did not feel that K.K. was receiving the same level of care.

When reported to the authorities: In response by mother to questionnaire from An Garda Síochána in June, 2014.

Response to allegations: Mrs. X was not interviewed with respect to the above. In this regard it should be noted that there was no specific allegation of wrongdoing made with respect to Mrs. X or Mr. X.

Outcome of Garda investigations: No prosecution recommended. The reasons for this are set out in the Garda report which will be available for any further investigations.

Public authority issues: From the information in the possession of the Commission, there are no allegations with respect to the conduct of public authorities in connection with K.K.'s placement for further investigation by the Commission in this case.

Case 4 – L.L.

Dates and/or duration of placement: 3rd August, 1983 – 10th August 1983, 5th July 1987 – 12th July 1987 and 23rd July 1989 for a few days.

Type of placement: Respite/Holiday Placement Scheme.

Age at time of placement: 12 to 17 years of age.

Disability issues: Yes.

Nature of allegations: An alleged incident of being left alone at the end of the road to be collected.

When reported to the authorities: To An Garda Síochána in 2014 in the course of their investigation into the placement.

Response to allegations: Mrs. X was interviewed by An Garda Síochána and she denied the allegation.

Outcome of Garda investigations: No prosecution.

Public authority issues: From the information in the possession of the Commission, there are no allegations with respect to the conduct of public authorities in connection with L.L.'s placement for further investigation by the Commission in this case.

Case 5 – H.H.

Dates and/or duration of placement: 9th to 16th July, 1989 and 25th/26th July, 1989.

Type of placement: Respite - Holiday Placement Scheme.

Age at time of placement: 7 years of age.

Disability issues: Yes.

Nature of allegations: Physical abuse: alleged that while in the Family X house “the man” hit him with the brush and poured cold water over him.

When reported to the authorities: To An Garda Síochána in 2016 in the course of their investigation into the placement.

Response to allegations: Mrs. X was interviewed by the Gardaí in 2018. She said that she did not recall H.H. and denied wrongdoing and any knowledge of wrongdoing in his case.

Outcome of Garda investigations: No prosecution recommended. The reasons for this are set out in the Garda report which will be available for any further investigations.

Public authority issues: H.H. has communicated with the Commission setting out his concerns arising from the findings made in the earlier published reports (referred to at Part II. e) of the Commission’s Terms of Reference) with respect to the failings of the SEHB and the HSE in connection with the placement. In essence H.H. states that the SEHB failed to protect him while he was in respite in the placement.

Note: H.H. gave further details of his allegations of physical abuse and his experience in the placement in both an email and a submission which were sent to the Commission on his behalf.

Case 6 – Y.Y.

Dates and/or duration of placement: 27th August, 1989 – one week.

Type of placement: Respite - Holiday Placement Scheme.

Age at time of placement: 12 years of age.

Disability issues: Yes.

Nature of allegations: An alleged incident of being locked in a cupboard by Mrs. X.

When reported to the authorities: Reported to mother (deceased) and sister shortly afterwards. As reported in Volume 1 of the Final Substantive Report, Y.Y. told Mr. Smith of this allegation in June, 2009. Y.Y. was interviewed by specialist Garda interviewers in September, 2014 (during which he did not repeat this particular allegation). His sister also made a statement to An Garda Síochána in 2014 in connection with the matter, in which it was suggested that the matter was communicated to someone in Y.Y.'s school.

Response to allegations: Mrs. X was interviewed by An Garda Síochána in 2018. She denied the allegation.

Outcome of Garda investigations: No prosecution recommended. The reasons for this are set out in the Garda report which will be available for any further investigations.

Public authority issues: From the information in the possession of the Commission, there are no allegations with respect to the conduct of public authorities in connection with Y.Y.'s placement for further investigation by the Commission in this case.

Case 7 – Z.Z

Aspects of this case have already been extensively reported upon by the Commission in Phase One having regard to the Terms of Reference set in Grace's case, which included inquiry into the manner in which the allegations made in this case were managed or addressed by the SEHB in 1992/1993.

These matters are reported upon in Volumes 1 and 5 of the Final Substantive Report.

Dates and/or duration of placement: 1988 to January, 1993

Type of placement: Private placement but introduced to placement by SEHB official.

Age at time of placement: 8 to 12 years of age.

Disability issues: Yes.

Nature of allegations: The allegations raised with respect to Z.Z. raised concerns of neglect, physical abuse and sexual abuse. Substantial detail with respect to these allegations and concerns and certain findings relevant to the evidence provided on these matters are reported in the above Volumes.

When reported and to whom: Reported to SEHB through Brothers of Charity Social Worker, as detailed in Volume 5 of the Final Substantive Report.

Response to allegations: Mrs. X's response to the allegations and her denial of them during the SEHB investigation in 1992/1993 and aspects of her evidence to the Commission have been reported in Volume 5. Mrs. X was also interviewed by An Garda Síochána in 2018 and she denied the allegations and any wrongdoing and knowledge of any wrongdoing in respect of Z.Z.

Outcome of Garda investigations: No prosecution recommended. The reasons for this are set out in the Garda report which will be available for any further investigations.

Public authority issues: As stated above, the public authority issues, and, in particular, the nature and manner of the SEHB investigation into the case in 1992/1993, have been reported in Volume 5.