FOREWORD

As the Insurer and Risk Management advisors to the Health Boards IPB is conscious of the huge increase in litigation in the area of child abuse over the past number of years. This publication is an attempt to assist the Boards to recognise potential risk areas, to implement procedures and protocols to protect children in care and, as a consequence, to avoid future claims.

Ann Power is a practicing barrister who has been involved in several child abuse cases on behalf of the Boards. She was originally involved in the McColgan v North Western Health Board claim and has, over the years, developed a specialist in-depth knowledge of all aspects of the legislation relating to this topic.

The whole area of childcare is constantly evolving and new legislation and Court decisions must be kept under review by all involved. We would hope that this document will assist Health Board personnel to re-evaluate current practice and that it will serve as a basis for the development of a structured Risk Management programme in this vital area of child protection.

The protection of children in care is obviously of primary importance and the implementation of risk containment strategies, as set out in this Report, should assist Health Boards to discharge their statutory duties in this regard.

LEGAL OPINION

Reducing the Risk of Civil Litigation

in

Child Protection Practices

Ann Power
Barrister-at-Law

Querist: Irish Public Bodies Mutual Insurances Limited

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OPINION

INTRODUCTION

I have been asked by Agent acting on behalf of Querist to advise Querist's clients, namely, the statutorily established health boards, in relation to reducing the risk of civil litigation in the context of child protection practices. This Opinion is preliminary and general in nature, as I have no instructions in relation to the specific practices that are deployed by any or all of the health boards. It offers broad, general principles that should guide the child care practice of health board personnel so as to reduce the risk of civil litigation arising out of their work with children at risk.

♦ Background to Child Abuse in Ireland

Child protection work is complex, uncertain and unpredictable and often requires a difficult and delicate balancing of conflicting interests. Awareness of the extent of child abuse within this jurisdiction has increased considerably since the publication in 1980 of the Department of Health's *Guidelines on Non-*

Accidental Injury to Children[1]. During the last twenty years various legislative and administrative reforms have taken place which were aimed at promoting the welfare of children culminating, to date, with the most recent publication in September 1999 of the National Guidelines for the Protection and Welfare of Children: *Children First*.[2]

Concomitant with increased awareness of the problem that child abuse posed in this jurisdiction, there came, slowly, at first, but with increasing rapidity, an upsurge in the number of civil actions taken against those organisations and institutions charged, statutorily or otherwise, with the care of children. The *Children Act, 1908* pre-dated the establishment of health boards and thus, did not impose upon them any specific statutory duties in relation to the care of children. However, since their establishment under the *Health Act, 1970* health boards had been assuming a role of care towards children in need of protection, often invoking the provisions of the 1908 Act in the execution of that role. Thus, when the extent of the social problem that is child abuse became known and survivors of abuse sought legal redress for the wrongs allegedly suffered, health boards, frequently, found themselves as defendants in civil actions. In December 1997 the High Court commenced its hearing of *McColgan -v- The Northwestern Health Board and Desmond Moran*. Lawyers hoped that the Court, in this case, would enunciate clear, legal principles that would guide the development of this expanding area of public law. However, the eventual settlement of the case postponed, until another day, the clarification of Irish law in this area.

[1] *Guidelines on the Identification and Management of Non-Accidental Injury to Children* [Department of Health, 1980].
[2] *Children First: National Guidelines for the Protection and Welfare of Children* [Dublin: Stationary Office, 1999].

Health boards should not assume that increased awareness of the problem of child abuse equates with a diminution in the incidence thereof. If child abuse in this jurisdiction was as vast a social problem as the plethora of civil actions and criminal trials would suggest, there is no valid reason for assuming that the phenomenon itself has diminished or disappeared. There is no justification for complacency at the present time. There are few, if any, grounds for believing that the problem has resolved and that litigation will cease as soon as "past" cases have been heard. Absent conclusive evidence of the fact that the incidence of child abuse has diminished dramatically, health boards should proceed on the assumption that children are as vulnerable and are as likely to be abused today as they were in the past. Today's children will become tomorrow's plaintiffs unless the legislative and administrative measures designed to protect them from abuse are working effectively, evaluated consistently and revised accordingly. Whilst the protection of children in need of care is of primary and paramount importance, the limiting of litigious actions through the development of risk containment strategies must also be addressed if health boards are to discharge, effectively, their statutory duties to children pursuant to the *Child Care Act, 1991*. The time consumed and resources depleted in the defence of civil actions might be more beneficially deployed in a system whose existing budgetary constraints are already restrictive. Thus, it is necessary, desirable and ultimately in the interests of children that health boards consider how best they can reduce, effectively, the risk of being sued *in the future.*

♦ <u>The Three Categories of Cases</u>

This Opinion deals, in a general way, with reducing the risk of litigation by examining three areas which, to date, have proved to be litigiously fertile ground and by suggesting broad, general principles that should guide practice in

each area. Plaintiffs in civil actions against health boards today tend to present themselves in one or other of the following categories:-

- those who allegedly suffered abuse as children within their own families in circumstances where, allegedly, the health board failed to intervene effectively and/or adequately so as to protect the child from the abusive family environment;

- those who, subsequent to having been taken into care by the health board, allegedly suffered abuse upon being placed within foster families approved by the board; or

- those who allegedly suffered abuse at the hands of employees, servants or agents of the health board and for whom the board may be liable, vicariously or otherwise, at law.

I shall, for ease of reference, refer to the first category of litigants as the "natural family" category; the second, as the "foster family" category and the third, I shall call the "employee" category.

CHAPTER ONE

LITIGATION
AND
THE NATURAL FAMILY

FAILING TO DETECT AND PROTECT CHILDREN AT RISK

Part A: The Statutory Duties of Health Boards

As a first and obvious step in reducing exposure to litigation, health boards should ensure that every employee[3] working in the area of child protection is aware, through effective training and education, of the board's duty to promote the welfare of children who are not receiving adequate care and protection. [The question of effective screening procedures for employees will be considered in due course.] The *Child Care Act, 1991* is the main legislative device established by the State for the welfare and protection of children. Specific, proactive training in the obligations legally imposed upon the board together with a detailed exploration and analysis of all that those obligations entail, must be a priority in any effort to reduce the risk of litigation in this area. Positive and effective staff development programmes designed to motivate every employee towards a sense of personal ownership of the board's objectives in the area of child protection can contribute towards generating the kind of environment where negligence is less likely to thrive.

Section 3(1) of the *Child Care Act, 1991* imposes upon a health board a positive statutory function to promote the welfare of children residing within its functional area.[4] The Act authorises the interference with familial relations whereby a child can be removed from the care, custody and authority of his parents and delivered into the care of a State agency, namely, a health board.

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[3]A collaborative approach to the duty imposed on health boards should be promoted and encouraged. Every person whose work touches upon child protection, ranging from the psychologist who interviews a child to the clerical officer whose function it may be to keep records in relation thereto, should be animated, through effective staff development programmes to "own" the objectives of the board in the context of child protection. Such a collaborative and personalised approach to the board's statutory duty would contribute to the creation of an environment less conducive to negligent activity and want of care.

[4]The need for the imposition of this positive duty was emphasised, unanimously, by the Supreme Court in *The State (D and D) v. Groarke* [1990 1 IR 303] where it held that a health board was not legally designated a "fit person" for the purposes of Section 24 of the *Children Act, 1908* under which health boards had been making applications to take children into care. As a consequence of that decision the *Children Act, 1989* was enacted, Section 1 of which provides that a health board is prospectively and retrospectively deemed to be a "fit person" conferred with the appropriate functions.

Section 3 of the *Child Care Act, 1991* provides:-

3.*—(1) It shall be a function of every health board to promote the welfare of children in its area who are not receiving adequate care and protection.*

(2) In the performance of this function, a health board shall—

(a) take such steps as it considers requisite to identify children who are not receiving adequate care and protection and co-ordinate information from all relevant sources relating to children in its area;

(b) having regard to the rights and duties of parents, whether under the Constitution or otherwise—

(i) regard the welfare of the child as the first and paramount consideration, and

(ii) in so far as is practicable, give due consideration, having regard to his age and understanding, to the wishes of the child; and

(c) have regard to the principle that it is generally in the best interests of a child to be brought up in his own family.

(3) A health board shall, in addition to any other function assigned to it under this Act or any other enactment, provide child care and family support services, and may provide and maintain premises and make such

other provision as it considers necessary or desirable for such purposes, subject to any general directions given by the Minister under Section 69.

A health board that fails to have regard for the various duties attaching to its statutory functions pursuant to Section 3 is likely to attract potential litigants from two sources:-

(i) parents whose rights are not adequately regarded; and
(ii) children whom the health board fails, initially, to detect and, subsequently, to protect.

Health boards should be conscious of the duties owed to both sectors in considering how best they might reduce the risk of civil litigation in the area of child protection

Part B: The Parent as Potential Litigant

Whilst I am concerned, primarily, with advising health boards in relation to their duties to children at risk, a preliminary consideration of the duties owed to parents is warranted in the context of reducing liability, generally. The main purpose of Section 3(2) is to strike a fair balance between the competing interests of children, parents and health boards, whilst regarding the welfare of the child as paramount. Whilst litigation, to date, has tended to come from children whose welfare was allegedly neglected, health boards should attend to the very real risk of being sued by parents whose rights have been denied or disregarded. Health boards are advised to have specific structures in place

which demonstrate, objectively, that due regard is had for the rights of parents as required by section 3(2)(b).

Section 3(2)(b) **obliges** health boards to have regard to the constitutional and other rights and duties of parents. Boards are also required to have regard to the principle that it is generally in a child's best interests that he be reared within his own family. In making decisions about children's welfare, health boards should be able to demonstrate, in practical terms, how adequate regard is had for parental rights. Health boards are further advised to keep written records of the manner in which such considerations are incorporated into the decision-making process. One of the consequences of the emerging litigation culture is that some professionals, fearful of being sued, may resort to a more cautious and defensive approach to their work. This fear, may, at times motivate them to act, not always in the best interests of the child or patient, but rather from a desire to avoid being sued.[5] At times, such defensive practices may result in a child being removed, unlawfully, from the care of his/her parents. The irony is, of course, that such defensive actions may, in fact, precipitate further litigation--the plaintiffs, this time, being parents alleging breach of constitutional and other rights.

The question as to whether a parent in such circumstances could bring an action in negligence and breach of statutory duty against a local authority was considered by the English courts. In *M (A Minor) and Another -v- Newham London Borough Council*[6] a mother and her child sued the local authority for its

[5]I became aware of the extent of this concern over litigation and the detrimental effects it has on the practice of professionals when addressing, recently, two Conferences in the University of Dublin, Trinity College -- *Reducing Liability in Medical Negligence* [October 1999] and *Suing Post-Primary Schools:- Strategies for Managers and Principals* [January 2000]. Many of the participants (health professionals, managers and teachers) confirmed that their practices have become more cautious and defensive in view of the increased risk of litigation.

[6][1995] 3 AER 353-401.

alleged failure to carry out its statutory duties with care. In *M.* the child, who had been sexually abused, was unnecessarily taken into care on the advice of a social worker and a psychiatrist who failed to take an accurate case history. The local authority obtained a court order removing M. from her mother and restricting access to her. When it became apparent that the psychiatrist had erroneously identified the abuser as the mother's co-habitee, the local authority recommended the rehabitation of the Plaintiff with her mother. By that time, however, the child had been separated from her mother for almost a year and both mother and child claimed to have suffered a positive psychiatric disorder as a result thereof.

When the matter came before the House of Lords, the Court acknowledged that very difficult decisions were involved in striking the balance between protecting the child from immediate feared harm and disrupting the relationship between the child and its parents. However, it decided, on public policy grounds, that it was just and reasonable for local authorities to enjoy immunity from suit in the discharge of their statutory duties. Thus, they held that no private cause of action in negligence and breach of duty arose. It is clear that both *M.* and the related matters of *X (Minors) v Bedfordshire County Council*[7] were products of "policy" considerations in Britain. In view of the natural rights of parents expressly acknowledged by the Constitution it is, in my view, unlikely that a Court in this jurisdiction would follow the reasoning of the English courts in such matters.

The decision of the House of Lords in *M. v Newham County Council* was appealed to the European Court of Human Rights and the progress of the appeal, to date, seems favourable to the appellants. The applicants complained

[7]Ibid., 353.

of an unjustified interference with their family life under Article 8 of the Convention and further complained that they had no access to a fair trial under Article 6. The Registrar of that Court recently issued a press release confirming that the European Commission had published its report in the case and had referred it to the European Court of Human Rights under articles 5 & 4 of Protocol No. 11 to the European Convention on Human Rights.[8] In its report, the Commission expressed the opinion that the conduct of the local authority had, in fact, constituted an unjustified interference with family life.

It has been recently reported that the European Convention will be incorporated into domestic law in this jurisdiction although the precise mechanism for such incorporation has yet to be determined. In my view, health boards that fail to have regard for parental rights in the discharge of their duties pursuant to Section 3 of the Act, would face serious difficulties in defending such disregard in view of the provisions of both the Convention and the Constitution. Thus, whilst the final decision of the European Court in *M. v The United Kingdom* is awaited, health boards seeking to reduce the risk of litigation in the future should adopt procedures that ensure that due regard is given to parental rights and duties in matters involving State intervention in families. Evidence of such regard should be well documented (for example, through records of consultations with parents) and capable of withstanding judicial scrutiny.

Part C: The Child as Potential Litigant

Breaches of Section 3 of the 1991 Act are also likely to attract a second group of potential litigants, namely, those children whose welfare it is the clear duty of

[8]Press Release of European Commission on Human Rights in *M v United Kingdom*, 5 November 1999.

the health board to promote. A noticeable feature of the child abuse litigation currently before the courts, is the repetition of the allegation of failure on the part of health boards in the past to take adequate steps to protect the child allegedly suffering abuse. A survey of such cases indicates that the intervention decision-making process is, clearly, an area where health boards have a risk exposure and one that needs consideration in determining how best to reduce the risk of litigation.

Risk Area 1: Exercising Discretionary Powers

♦ Decisions Involving Discretion

Section 16 of the Act of 1991 imposes upon a health board a statutory duty to instigate care proceedings in respect of a child in its area who requires care and protection. The duty so to do, it will be noted, arises after a board has come to a decision in respect of a child in need of protection. The process by which a board comes to such a decision involves the exercise of discretion. The section provides:

> *Where it appears to a health board with respect to a child who resides or is found in its area that he requires care or protection which he is unlikely to receive unless a court makes a care order or a supervision order in respect of him, it shall be the duty of the health board to make application for a care order or a supervision order, as it thinks fit.*

In spite of the apparent *carte blanche* which expressions like "where it appears" and "as it thinks fit" seem to bestow, health boards should not assume that such discretionary phrases will protect them from liability in the event of an alleged

breach of the duty expressly imposed by this section. A board that is sued for failing, *inter alia*, to take a child into care will not, in my view, defend itself successfully, merely by the assertion that such action "did not appear" to be warranted. Certainly, the nature of the duty to instigate proceedings confers upon a health board a degree of discretion. However, ***it is, precisely, in the exercise of its discretion that a health board is most vulnerable to litigation*** and it is an area where attention needs to be focused if the risk of litigation in the future is to be reduced. Consideration, therefore, must be given to how discretionary powers ought to be exercised by health boards so that the risk of incurring liability (in negligence, breach of duty and/or breach of constitutional rights) in respect thereof may be diminished.

♦ <u>The Standard of Care</u>

The *Child Care Act, 1991* is silent as to whether breaches thereof will give rise to a private cause of action. One cannot predict, with certainty, the standard that a court would use if it were deciding whether a claim in negligence against a health board should be allowed. In this regard one might, usefully, consider other legislative enactments. Section 260 of the *Mental Treatment Act 1945*, as amended, provides that where a plaintiff seeks damages in respect of a wrong committed pursuant to the exercise of statutory powers, such a plaintiff must establish that the defendant acted, *inter alia*, ***without reasonable care***. It is arguable that a Court would apply a similar test in determining whether a health board was negligent and/or in breach of duty in the manner in which it exercised its discretionary powers.

In the exercise of discretionary powers, such as, the one provided for Section 16 of the Act of 1991, health boards should ensure that decisions taken in respect of children are such that they can demonstrate that **<u>reasonable care</u>** was taken

in the making thereof. Clearly, every decision is contextual but the standard principles of reasonableness in negligence should be applied consistently and without exception. These principles, generally used by a Court in assessing whether conduct is negligent, are: (a) the probability of the threatened injury occurring; (b) the gravity of the threatened harm; (c) the social utility of the defendant's conduct; and (d) the cost of eliminating the risk involved. Persons empowered to exercise discretion, such as, in deciding whether or not to instigate care proceedings, are advised to have documentary evidence available which establishes that, in arriving at a decision, all reasonable care was taken. So, for example, in the context of a Section 16 decision, such persons would, in my view, be required to show that due consideration was given to the following questions:-

(i) What is the *probability* or likelihood of harm occurring to the child if the board fails to instigate proceedings?
(ii) What is the *gravity* of the threatened harm to the child? and
(iii) What is the *cost of preventing* this harm?

Addressing each of these issues will not, of itself, immunise a health board from suit. Rather, these factors should always be forefront in the minds of the decision-makers because they serve as criteria that the court will use to determine the reasonableness or otherwise of the decision/action of a health board in all of the prevailing circumstances.

The greater the likelihood of harm to a child, the more probable it is that a Court will regard it as unreasonable (and thus, negligent) for a health board to fail to take steps to protect that child. Where the potential injury to a child is great then a Court may find that even a slight risk (such as, delaying to take action for

two or three hours) may constitute negligence. The gravity of a threatened injury is a relative matter and whilst the calculated risk of abuse occurring may be the same for two children, the results may be far more serious for one than the other. In assessing alleged negligence the Court will, undoubtedly, have regard to the high social utility of the work of health boards in this difficult and complex area. Generally speaking, a high social utility will be regarded with more indulgence than where a defendant's conduct confers little or no social benefit. This factor weighed heavily in the deliberations of the House of Lords in the *Bedfordshire* cases, mentioned earlier. That said, however, this is only one of four factors to which the Court will have regard in assessing negligence. Where an injury occurs in circumstances where the probability of injury was high and the threatened gravity severe, then the high social utility of the defendant's conduct at the relevant time will not, in my view, be sufficient to resist a claim in negligence. Finally, some consideration will be given to the cost of eliminating the risk of injury. However, it must be stated that the cost factor tends to lose most of its force where the risk of injury is substantial. Similarly, a "lack of resources" plea would not, in my view, be met with much sympathy by a Court where a child was seriously injured in circumstances where such injury was reasonably foreseeable.

The assessment of the standard of care is different, of course, where the acts/omissions of health board professionals, such as, psychiatrists and psychologists are involved. In such cases the principles enumerated by the Supreme Court in *Dunne v National Maternity Hospital and Another*[9] will apply. The House of Lords in *Bolitho v City and Hackney Health Authority*[10] has recently adopted the same principles.

[9][1989] IR 91 at 101.
[10][1997] 4 AER 771.

♦ Cases of Doubt

A health board is obliged to institute care proceedings where it appears to it that it is unlikely that a child in its area will receive care or protection unless a care or supervision order is made. The Act of 1991 provides for various types of orders being made by the Court in respect of a child brought to its attention including an emergency care order,[11] an interim care order,[12] a care order committing the child to the care of the health board for so long as he remains a child or for such shorter period as the court may determine,[13] and a supervision order.[14] Section 16 imposing as it does on health boards the duty to instigate care proceedings in the circumstances specified therein, implies that the health board has formed the view that conditions exist for a successful application.

However, there may arise circumstances where the conditions pertaining to a particular child are not unequivocally indicative of child abuse. Suspicions regarding the welfare of a child may arise where little concrete evidence may be available to confirm or substantiate such concerns. A child may make an allegation of abuse and then, subsequently, retract it. Investigations, following a report of suspected abuse, may yield little by way of corroborative evidence. Sometimes, health board personnel may have no more than a recurrent and persistent doubt in relation to the welfare of a particular child. How ought a health board respond in such situations so as to reduce the risk of subsequent litigation?

An example of the kind of uncertainties that may prevail in some cases may be seen in the matter of *Re H (Minors) (Wardship: Sexual Abuse)*[15] the facts of

[11]Section 13.
[12]Section 17.
[13]Section 18.
[14]Section 19.
[15][1991] 2 FLR 416.

which may be summarised, briefly, as follows. The case concerned four children, E, C, R and N. The mother of the first three was the sister of the fourth child's mother. Both families lived together in one household and the living arrangements were highly undesirable. R's mother noticed that R had blood on her pants and she contacted her local General Practitioner who referred the child to a Consultant Paediatrician. The consultant's findings were "highly suggestive" of child sexual abuse and the local authority was notified. The authority obtained a place of safety order and commenced wardship proceedings, which had the effect of making all four children wards of court. Medical examinations and video-taped interviews of the other three children were described as "negative" and there was no physical evidence of sexual abuse of E, C or N. Notwithstanding these findings the local authority sought interim care orders in respect of all four children in view of the presumed risk which, it stated, must attach given the history of R. The parents opposed the application and the Court at first instance dismissed the local authority's application. In making his determination Heald J opined that an investigation into a case might disclose that the existence of child abuse is either

- a remote possibility;
- a real possibility;
- a distinct possibility; or
- a probability.

He stated:

> *I take the view that I am here left with a case where there is a real possibility that R has been sexually interfered with. It is no higher than*

that, and on the scale of remote possibility, real possibility, distinct possibility and probable, it is fairly low on the scale.[16]

He made an order continuing the wardship proceedings but returned the children into the care of their parents with a supervision order in favour of the authority. The local authority appealed.

Dismissing the appeal the Court of Appeal held that in cases involving allegations of sexual abuse of children the judge must exercise his discretion in two stages in the decision-making process. The first stage required an evaluation of the evidence of fact and expert opinion in order to determine (a) whether there was evidence of sexual abuse; and (b) if so, whether there was evidence of the identity of the abuser. The second stage of the decision-making process required a judicial exercise of discretion, with the test of the welfare of the child paramount. In doing so, it held, that the court should have regard to the danger that in seeking to protect children from sexual abuse (by placement with foster-parents, however loving and skilled), society might cause other, and possibly greater harm to children by taking them away from the only home they might have known and from parents, however inadequate, to whom they were attached. Against the risk of possible further abuse of R, there had to be balanced all the risks of removing her and her siblings from their parents, siblings and extended family. The Court of Appeal held that Heald J had correctly balanced those risks. However, the Court noted that frequently local authorities are faced with situations, such as this one, that give rise to doubt. It concluded that refusals of their applications for care orders should not discourage them from acting in cases of uncertainty. Balcombe LJ stated:-

We wish to make it clear that in no way do we seek to criticise the council

[16]Ibid. at 419.

for making the application before Judge Heald, nor for appealing his order to this court. Society has entrusted local authorities with this difficult and demanding task of protecting children from abuse. In the exercise of this task they, and the social workers who have to do the work on the ground, will always be exposed to criticism. If they do not seek to remove a child who is at risk of abuse (whether sexual or otherwise) from its home, and that child is subsequently abused, or even, in the worst cases, killed, they are criticised. If, on the other hand, they do seek to remove a child whom they believe to be at risk, they are criticised as being authoritarian and for disregarding parental rights. They must always be entitled to bring a case before the court, upon which the burden of decision then rests.[17]

Health boards, in this jurisdiction, seeking to reduce the risk of litigation are advised to avoid second-guessing legal determinations.[18] Whilst no amount of legal advice will immunise a health board from the risk of suit, there is, in my view, one standard rule that health boards should apply in circumstances where doubts and uncertainties prevail in relation to the welfare of a child. Notwithstanding its duty to have regard to the rights of parents,[19] ***in cases where doubts and uncertainties about the safety and welfare of a child prevail, a health board should bring the matters before the Court and make the appropriate application pursuant to Section 16 of the Child Care Act, 1991***. If erroneous decisions are to be made in such delicate and difficult circumstances then, in my view, it is preferable that those determinations are made by the Court "upon which the burden of decision rests". The High Court, in this jurisdiction, has also confirmed recently, albeit in a slightly different context, that the ultimate responsibility for children in need of care rests with

[17]Ibid. at 424.

[18]This applies to all decisions made that affect the legal rights of third parties including, children, parents, foster-parents, employees, servants or agents. Seeking legal assistance *after* the fact is only of assistance in the context of damage limitation. Where possible, legal advice should be sought *prior* to taking action in circumstances that give rise to concern.

[19]And the manner in which this duty is discharged should, in every case, be documented and recorded.

the Court.[20]

That said, however, immunity from suit can never be guaranteed. It must be emphasised that the general application of this standard rule in cases of doubt will not, necessarily, absolve a health board from the risk of suit. For example, a health board may be informed by a clinician that there is physical evidence indicative though not conclusive of child sexual abuse in respect of a particular child. Acting on the "*If in doubt . . "* principle, as stated above, a health board may instigate proceedings and put the clinician's evidence before the court. A court, having heard the evidence, may make a care order on foot of the application. If it, subsequently, transpires that the clinician's evidence was unreliable,[21] then a health board may still find itself liable, either directly or vicariously, for the damage allegedly caused to the parents and/or their child as a result of the forced separation. If the possibility of suit remains even in a case such as this where the margin of doubt appeared slim then it is all the more possible where the doubts are greater and the evidence less compelling.

♦ <u>The National Guidelines</u>

In September 1999 the Department of Health and Children published new National Guidelines for the Protection and Welfare of Children entitled *Children First* (hereinafter referred to as the *"Guidelines").* As in the case of the *Child Care Act, 1991*, health boards should ensure that every employee, servant or agent, working in the area of child protection is aware of and adheres to the *Guidelines*. Once again, effective training programmes in the

[20] *Eastern Health Board v McDonnell* [1999] 1 IR 174.

[21] I have in mind a particular case wherein a clinician made a diagnosis of child sexual abuse on the basis of an examination of a child which disclosed evidence of anal interference. On the basis of her diagnosis an emergency order was obtained and the child (who was already in hospital for a routine procedure) was removed from the custody of its parents. Subsequently, it emerged that the child had previously suffered from a bowel disorder which necessitated external anal stimulation in order to assist with the evacuation of the bowels and this accounted for the physical findings of anal interference.

understanding and implementation of *Children First* should be instituted in every health board area as part of a concerted effort to reduce the risk of litigation against health boards. Thereafter, continuous and effective evaluation programmes should be put in place so as to ensure that compliance with the *Guidelines* is an intrinsic feature of child protection policy within each health board area.

That said, however, health boards may, at times, have to exercise a discretion as to the manner in which the *Guidelines* are implemented in any given context. *Children First* should be regarded as representing the minimum standards that ought to prevail in the area of child protection. At times, prevailing circumstances may require that the standards of care laid down therein be exceeded if a board's duty is to be discharged. Thus, the *Guidelines* ought not to be regarded as inflexible rules that must be followed in every situation regardless of what the actual circumstances pertaining thereto require. *Children First* is no more than a set of guidelines that should inform child protection practice but rigid adherence thereto will not always protect health boards from liability in negligence. If, in practice, it transpires that some provisions of the *Guidelines* are inherently defective and that such defects ought to have been obvious to any practitioner giving the matter due consideration then the mere fact of compliance with the *Guidelines* alone will not, necessarily, be sufficient to defeat a claim in negligence. In this regard the *Guidelines* should be kept under continuous review and scrutiny both as to content and operation thereof.

Risk Area 2: Identification and Response

♦ The Identification Process

Apart from the risk attendant upon exercising discretionary powers, it would appear from the cases currently before the courts that another area of vulnerability for health boards is the manner in which they identify and respond to children in need of protection. Section 3(2)(a) of the *Child Care Act, 1991* obliges a health board

> "*to take such steps as it considers requisite*[22] *to identify children who are not receiving adequate care and protection and co-ordinate information from all relevant sources relating to children in its area*".[23]

I have no instructions in relation to the steps actually taken by any health board in fulfilling its obligation pursuant to this provision. However, in the event of litigation it would, in my view, be necessary for a board to establish that:-

(i) *effective structures for the identification of children at risk were in place;*

(ii) *effective structures for the efficient processing of information in relation to children at risk were in operation; and*

(iii) *effective structures for responding adequately to such information were in place.*

Whilst offering fairly detailed guidelines on the assessment and management of reported cases of child abuse and the importance of inter-agency co-operation, *Children First* does not outline, with any degree of specificity, what steps ought

[22] See above on the requirements of reasonableness in the exercise of such a statutory discretion.

[23] Section 3 (2)(a).

to be taken by health boards in fulfilling their statutory duty to *identify* children in need of protection. The *Guidelines* merely state that boards must "*be open to receiving information*"[24] about such children.

Some of the litigation against health boards includes the allegation of a failure to detect that plaintiffs were suffering abuse. How, therefore, ought health boards discharge their duty to identify children at risk? It is reasonably clear from a perusal of the relevant authorities that once a duty of care has been established. The standard of care required for the performance of that duty must be measured against the yardstick of reasonable conduct on the part of a person in the position of that person who owes the duty. Thus, in determining whether or not a particular board fulfilled its statutory obligation of identifying children at risk, a Court would consider what a reasonable health board would do in order to identify minors in need of care.

In this regard, consideration should be given to the standards of practice currently deployed by other health authorities charged with similar functions. It would appear to me that minimum standards would require the existence of structures which permit school teachers, paediatric care workers, general practitioners, youth workers and other persons who work with children, to have regular, organised contact with health boards for the purpose of identifying possible cases of children at risk.

The *Guidelines* state that a health board

> "*must be open to receiving information from any source about any child in its area who may not be receiving adequate care and protection*".[25]

[24] *Children Firs*t, Section 6.4.3(i).

[25] Ibid.

A close reading of the *Child Care Act, 1991* confirms, however, that the wording of section 3(2)(a) does not limit a health board's duty to those children whose cases actually come to the attention of the board. Its duty is to children in its area who are not [*in fact*] receiving adequate care and attention.[26] In discharging that general duty a health board, as noted earlier, is obliged to take steps (as it considers requisite[27]) to identify children at risk.[28]

Generally, a defendant in an action for negligence will be liable in circumstances where it was reasonably foreseeable that his act/omission was likely to cause the damage or injury of which the plaintiff complains. In other words, the question of whether a defendant knew or ought to have known is a pivotal factor in determining liability. In some child abuse cases a defence may lie in the claim that the defendant health board did not, in fact, know nor could reasonably have known that the plaintiffs were at risk. However, much of the present litigation pre-dates the implementation of Section 3 of the *Child Care Act, 1991*.[29] Whether a court would hold that section 3(2)(a) now requires a health board to take positive, proactive steps to seek out ("identify") children at risk (as opposed, merely, to having structures in place which enable others to bring children to its attention) is open to debate. In determining the requirements of a health board's duty to identify children at risk a court would, in my view, seek to strike a balance between precautions which are acceptable and those which are excessive.[30]

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[26]Section 3(1).
[27]Its consideration in this regard must be reasonable in all the circumstances. See pages 16-19 herein on exercising discretionary powers.
[28]Section 3 (2)(a).
[29]This section commenced on 1 December 1992 pursuant to S.I. 349 of 1992.
[30]Authority for this proposition may be found in *Bolger v Governor of Mountjoy Prison & Others* [Unreported, High Court, O'Donovan J., November 12 1997].

Children First is a comprehensive and extensive publication directed, generally, to the public at large, but more specifically to social workers and other health professionals whose work brings them into regular contact with children. However, it is arguable that, save for few exceptions, members of the wider community are unlikely to read this comprehensive and detailed publication. And yet, if the clandestine and furtive abuse that occurs within the powerful bastion of the family is to be detected ("identified") and prevented, it is to those ordinary members of the wider community that health boards may be obliged to turn in their efforts to identify children at risk. It may be that it is the child's local shop-keeper or bus driver, aunt or uncle, friend's mother or brother, who, if sufficiently vigilant, is in the best position to detect and report instances of child abuse.[31]

A health board concerned to discharge its duties to children at risk and thus, limit its exposure in negligence should give careful consideration to the *practical* requirements of section 3(2)(a). Health boards should ensure that the structures which are in place satisfy those requirements. Health boards need to ask: What practical steps are in place for the identification of children at risk? How adequate are those steps? Are such steps reasonable in all the circumstances? Appropriate expert advice on measures to maximise identification of children at risk should be obtained and implemented in this regard. In this context, health boards may consider the value, if any, of implementing public education programmes aimed at encouraging the local community to be vigilant with regard to the welfare of children. Clearly,

[31]A noticeable feature of child abuse cases is the efforts allegedly made by the alleged abuser to keep the victim away from persons or bodies, such as, youth clubs or doctors, who might reasonably be expected to raise questions in relation to the welfare of the child. Consequently, such children may "slip through" the net and remain undetected. Knowledge of this tendency may raise the standard actually required of a health board pursuant to Section 3(2)(a).

whatever "steps" are taken having regard to Section 3(2)(a), it is advisable that such steps are standardised and implemented by all health boards.

♦ Collation and Response

Once a health board has fulfilled its duty to identify children in need of care and protection, the next step in fulfilling its obligations requires that reasonable structures are in place for the efficient processing of and response to information received about children at risk. The 1999 *Guidelines* refer to the Child Protection Notification System as "a record of every child about whom, following a preliminary assessment, there is a child protection concern".[32] This Notification System would appear to be broadly similar to the Child Protection Register in the United Kingdom.

♦ Record Keeping

The *Guidelines* stress the importance of keeping records in relation to child protection issues. Section 8.18.7 provides:

> *All professionals and agencies involved must keep a contemporaneous record of all steps involved in enquiries and assessments. Case files should record all decisions, including a decision not to proceed with an enquiry, and specify the evidence or reasons upon which these are based. Records must always be easily accessible in the absence of a worker.*

The importance of keeping accurate and contemporaneous records cannot be overstated in the context of seeking to reduce the risk of litigation against health boards. Clearly, the protection of children in need of care is the primary objective of the *Child Care Act, 1991*. However, that objective can best be achieved where accurate and systematic records are maintained in relation to

[32] Section 8.15.1

children brought to the attention of health boards. The *Guidelines* also provide that records should always document the outcome of an investigation and assessment of a child protection concern under one of the following headings:-

(i) Confirmed abuse;
(ii) Assessment ongoing;
(iii) Inconclusive outcome;
(iv) Confirmed non-abuse/unfounded.[33]

In my view, where an investigation of a child protection concern results in an "inconclusive outcome" a health board must be sure to record the precise steps that were taken in such a situation so as to ensure that its duty to the child in question was discharged. The *Guidelines* provide that "the management of records held by the health board social worker or other designated key worker should *be standardised in each health board area*".

The *Guidelines* recommend consistent follow-up and evaluation of decisions taken in respect of children whose names have been entered upon the Child Protection Notification System. Health boards are advised to ensure that such follow-up is recorded and that it is specific and task oriented. Vague terms, such as, "consult", "monitor", "survey" are, where possible, to be avoided and the specific, practical steps to be taken in respect of the promotion of each child's welfare should be recorded. A system for checking that the decisions recorded were, in fact, implemented should also be deployed.

Compliance with the *Guidelines*, as minimum standards, should be ensured in the context of risk reduction. Health board personnel should also ensure that

[33] Section 8.18.8.

structures are in place which enable practitioners to report any defects in the child protection system which become obvious as the *Guidelines* are implemented.

♦ The Designated Person

The recommendation in Section 1.3.3 of the *Guidelines* should be noted and implemented by health boards as part of the containment of litigation risks. That section provides:-

> *Each organisation should designate responsibility to a specific member of staff for ensuring that procedures and arrangements are in place within the organisation to protect children in line with these National Guidelines.*

Some consideration is given at the end of this Opinion to the benefits of appointing a Risk Manager within each health board. Such a person's function would incorporate those of the "designated person" recommended in the *Guidelines.* Regular periodic meetings should take place between such an official, the General Manager and Child Care Managers. Resources within health boards may be limited and demands made upon child care practitioners extensive. However, in the context of reducing the risk of litigation, generally, the appointment of an expert whose primary function would be the monitoring, evaluation and improvement of child protection practice would, in my view, be warranted. This would assist health boards in the effective discharge of their statutory duties. When duties are effectively discharged the risk of litigation diminishes.

Part D: The Legal Basis Actions

Whilst Irish law remains in a state of uncertainty with regard to the liability of a health board in the event of abuse suffered by a child within its area, one can, at this point, say that health boards *may* be liable in damages if the act complained of constitutes:

(i) a breach of statutory duty;
(ii) the commission of a recognised tort, such as, trespass or negligence;
(iii) an infringement of a personal constitutional right.

♦ Breach of Statutory Duty

The *Child Care Act, 1991* imposes numerous statutory duties upon health boards to promote the welfare of children within their respective functional areas. Arguably, one of the most important duties is the duty to instigate care proceedings pursuant to Section 16

The question arises as to whether a breach of statutory duty on the part of a health board will give rise to a private cause of action within this jurisdiction. Very occasionally a statute will state explicitly that breach of the statute does[34] or does not[35] give rise to a cause of action. Generally, however, the statute will be silent on the matter and the courts will engage in the fictitious exercise of imputing legislative intention in order to determine whether a cause of action follows on foot of a breach of statutory duty.

[34]See, for example, *Competition Act 1991*, section 6; *Electoral Act 1992* section 159.
[35]See, for example, *Post and Telecommunication Services Act 1983*, section 15(2); *Litter Pollution Act 1997* section 14 (no action for damages by reason of failure of local authority to exercise their statutory functions).

This "fictitious" exercise was conducted in the United Kingdom in the decision of *X v Bedfordshire.* Lord Browne-Wilkinson held that where difficult and sensitive decisions have to be taken in a statutory framework, very clear language would be needed to establish a right to damages under Statute where an erroneous decision was taken. Such a right, he concluded, was not to be found in the *Children's Act 1989.* He went on:-

> *Most statutes which impose a statutory duty on local authorities confer on the authority a discretion as to the extent to which, and the methods by which, such statutory duty is to be performed. It is clear both in principle and from the decided cases that the local authority cannot be liable in damages for doing that which Parliament has authorised. Therefore if the decisions complained of fall within the ambit of such statutory discretion they cannot be actionable in common law.*[36]

The same question was considered by the High Court in this jurisdiction in *Stephens v The Eastern Health Board*[37] where Geoghegan J examined the matter in the context of *The Child Care Act 1999* and stated:-

> *I take the view that no breach of any of the provisions of the Child Care Act 1999 gives rise to an action for damages for breach of statutory duty. Breaches of the Act can be remedied by Judicial review because that will ensure the actual performance of the duties as distinct from absolution for performance in return for money.*

[36] [1995] 3 AER 353 at 736.
[37] High Court, 17 July 1994.

Breach of Common Law Duty

Health boards, in my view, should be slow to take solace from the judgments cited herein. Whilst those cases may suggest that health boards will not be held liable in damages for breaches of statutory duties, they do not, by any means, address all of the relevant legal considerations. *Stephens* may represent a statement of Irish law on the narrow question of damages for breach of a health board's statutory duty, [and I am not convinced that this decision would be upheld today]. That aside, however, a health board in breach of its duties to children in this jurisdiction could, in my view, be found liable in damages if the act complained of constituted the commission of a recognised tort, such as, negligence or trespass.

In *X v Bedfordshire* the House of Lords, refused to impose a common law duty of care on local authorities having regard to the difficult circumstances in which such authorities often exercise their discretionary powers. It recognised that the task of an authority and its servants in dealing with children at risk is extraordinarily delicate in that the work is inter-disciplinary, involving the participation of the police, educational bodies, doctors and others. Their Lordships cited from the *Report of the Inquiry into Child Abuse in Cleveland 1987* which stated:

> *It is a delicate and difficult line to tread between taking action too soon and not taking it soon enough. Social services whilst putting the needs of the child first must respect the rights of the parents; they also must work if possible with the parents for the benefit of the children. These parents themselves are often in need of help. Inevitably, a degree of conflict develops between those objectives.*[38]

[38] *Report of the Inquiry into Child Abuse in Cleveland* (1987) at 244.

In the *Bedfordshire* cases the Court concluded that it would not be just and reasonable in such circumstances to impose a common law duty of care on the local authority in relation to the exercise of its powers and duties. Accordingly, it held that a claim for damages in negligence failed as being non-justiciable.[39] The Court further held that a local authority was not vicariously liable for the actions of social workers and psychiatrists instructed by it to report on children who were suspected of being sexually abused. Once again, its rationale was that it would not be just and reasonable to impose such a duty of care on the local authority as it would be contrary to public policy so to do.

There is no doubt that the reasoning of their Lordships in the *Bedfordshire* cases is incontrovertibly based on policy considerations and such cases would not, in my view, be of persuasive authority in this jurisdiction. The kind of immunity granted to local authorities in Britain would only be regarded by the courts in this jurisdiction as a requirement of the common good where such bodies act bona fides "*and without negligence*".[40]

A court in this jurisdiction would not, in my view, deny the existence of a common law duty of care on a health board such as would amount to a "blanket immunity" from suit for the negligent exercise of discretionary powers. Whilst public authorities, in this jurisdiction, are subject to broadly the same common law of tortious liability as private individuals or companies,[41] the question of liability, in this context is not, essentially, about operational torts, as such. Rather, the question is whether the negligent exercise of a function *peculiar* to a

[39]However, it went on to say that if the claim against the local authority *were* justiciable then the ordinary principles of negligence (whether the damage was reasonably foreseeable, whether there was proximity of relationship between the parties and whether it would be just and fair and reasonable to impose a duty of care) would apply.
[40]*Per* Finlay C.J. in *Pine Valley Developments Ltd. v Minister for the Environment* [1987] IR at 23.
[41]Hogan and Morgan, *Administrative Law in Ireland* (3rd ed.) at 829.

public body gives rise to liability in damages. The relevant principles in cases of this kind were enunciated by Costello J. in *Ward v McMaster*[42] and they are as follows:

(a) *When deciding whether a local authority exercising statutory functions is under a common law duty of care the court must firstly ascertain whether a relationship of proximity existed between the parties such that in the reasonable contemplation of the authority, carelessness on their part might cause loss. But all the circumstances of the case must in addition be considered, including the statutory provisions under which the authority is acting. Of particular significance in this connection is the purpose for which the statutory powers were conferred and whether or not the plaintiff is in the class of persons which the statute was designed to assist.*

(b) *It is material in all cases for the court in reaching its decision on the existence and scope of the alleged duty to consider whether it is just and reasonable that a common law duty of care as alleged should in all the circumstances exist.*[43]

In my view, it appears likely that where a child suffered injury as a result of abuse in circumstances where a health board negligently failed in its duty to provide care and protection, a Court would have little difficulty in concluding that:-

(a) a relationship of proximity existed between a health board and such a plaintiff;

(b) such a plaintiff belongs to the class of persons which the *Child Care Act, 1991* is designed to assist; and

(c) it would be just and reasonable in all the circumstances to impose a

[42][1985] IR 29.
[43]Ibid. at 49-50.

common law duty of care on a defendant health board.

♦ Breach of Constitutional Right

Finally, a plaintiff in this jurisdiction may also succeed against a health board on the grounds that failure to provide the requisite care and protection amounted to an infringement of a personal constitutional right. The willingness of the courts to countenance a re-shaping of remedies in the light of the Constitution is nowhere more evident than in the context of the law of torts.

> *Where an existing tort is ineffective to protect constitutional rights, the courts may either modify the definition of the tort or permit the Plaintiff to sue directly for infringement of constitutional rights.*[44]

This development has significant implications in the context of litigation involving child sexual abuse where, to date, plaintiffs are still met with the existing provisions of the *Statute of Limitations 1957-91*.[45] Many actions are being framed in terms of a breach of constitutional rights, presumably, because the criteria for determining liability for infringement of constitutional rights are not, necessarily, identical with those appropriate to tort law. Additionally, an action for breach of constitutional rights, unlike an action in tort, would not be subject to the same limitation periods.

Thus, whilst a plaintiff in this jurisdiction may fail in a claim for breach of statutory duty, he or she may, nevertheless, succeed if the breach in question can be characterised either as negligence *simpliciter* or as a negligent breach of his or her constitutional right.

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[44]Kelly, J. *The Irish Constitution* (3rd ed.) at 708.
[45]*The Statute of Limitations (Amendment) Bill 1999* which seeks to extend the current limitation period in cases of child abuse is currently before the Dáil.

CHAPTER TWO

LITIGATION
AND
THE FOSTER FAMILY

THE NEGLIGENT PLACEMENT OF CHILDREN IN CARE

Part A: The Duty to Children

Some of the litigation currently before the Courts in this jurisdiction involves allegations of abuse, negligence and want of care against health boards in failing, subsequent to having taken children into care, to provide adequate care and protection.

Where a child is in the care of a health board, that board has a statutory duty pursuant to Section 36 of the Act of 1991 to provide care for the child, subject to its control and supervision. That section provides:

> *36.—(1) Where a child is in the care of a health board, the health board shall provide such care for him, subject to its control and supervision, in such of the following ways as it considers to be in his best interests—*
>
> *(a) by placing him with a foster parent, or*
>
> *(b) by placing him in residential care (whether in a children's residential centre registered under Part VIII, in a residential home maintained by a health board or in a school or other suitable place of residence), or*
>
> *(c) in the case of a child who may be eligible for adoption under the Adoption Acts, 1952 to 1988, by placing him with a suitable person with a view to his adoption, or*
>
> *(d) by making such other suitable arrangements (which may include placing the child with a relative) as the health board thinks proper.*
>
> *(2) In this Act, "foster parent means a person other than a relative of a child who is taking care of the child on behalf of a health board in accordance with regulations made under section 39 and "foster care" shall be construed accordingly.*

This part of the Opinion addresses how health boards can reduce the risk of litigation arising out of its management of children taken into care and placed, subsequently, with foster parents.

The *Child Care (Placement of Children in Foster Care) Regulations, 1995* came into effect on the 31st October 1995. As a first and obvious step in reducing exposure to litigation in the "foster family" category, a health board must ensure that its personnel are entirely familiar with and adhere in practice to the statutory regulations in relation to the placement of children in foster care.

♦ The Child Care (Placement of Children in Foster Care) Regulations, 1995

As in all child care legislation currently in force within the State, the 1995 Regulations provide that in any matter relating to the placement, review or removal of a child in foster care, the welfare of the child should be the first and paramount consideration of a health board.[46] In fulfilling its obligation in this regard, a health board is obliged to have regard to the constitutional and other rights and duties of parents and, in so far as is practicable, the wishes of the child.

A health board is under a duty to establish and maintain one or more panels of persons who are willing to act as foster parents.[47] Regulation 5(2) sets out "screening procedures" and provides that a health board shall not place persons on its foster parents' panel unless:-

(a) those persons have furnished to the board—

[46]Regulation 4.
[47]Regulation 5(1).

(i) a written report by a registered medical practitioner on their state of health,

(ii) the names and addresses of two referees who are not related to them and whom the board may consult as to their suitability to act as foster parents,

(iii) all necessary authorisations to enable the board to obtain a statement from the Garda Síochána as to whether any convictions have been recorded against them, or against other relevant members of their household, and

(iv) such other information as the board may reasonably require;

(b) an assessment of the suitability of those persons and their home has been carried out by an authorised person;

(c) a report in writing of the assessment has been considered by a committee established under sub-article (3) of this article and the committee is satisfied, having regard to the said report and the information furnished to or obtained by the board pursuant to this sub-article, that they are suitable persons to act as foster parents on behalf of the board; and

(d) those persons have received appropriate advice, guidance and training in relation to the foster care of children.[48]

The 1995 Regulations impose numerous obligations upon health boards. A health board is obliged to endeavour to ensure that foster parents have the capacity to meet the needs of the child placed in their care.[49] It is further obliged to enter into a contract with persons whom it has placed on a panel maintained by it under article 5 of the Regulations. It must furnish prospective foster parents with specific information[50] on the child and must prepare a care plan, in consultation with the prospective foster parents, before placing a child in their care.[51]

[48]Regulation 5(2).
[49]Regulation 7.
[50]Particulars of information are set out in the Second Schedule.
[51]Regulation 11.

Foster parents are under a general duty to take all reasonable measures to promote the child's health, development and welfare and are under a specific duty to comply with the provisions of Regulation 16(2).[52] Health boards are under a duty to supervise and visit children in foster care as often as the board considers necessary but a certain minimum number of visits is obligatory.[53] A note of every visit must be entered into the child's case record together with particulars of any action taken as a result of such a visit. The 1995 Regulations impose upon health boards the duty to review the case of each child placed in foster care periodically and a health board must have regard to all of the matters laid down in Regulation 18 when conducting such a review.[54] Where a health board considers that the continued foster placement of a child is no longer the most appropriate way of performing its duty under Section 36 of the 1991 Act it has the power to remove the child from foster care.[55]

Clearly, compliance with the 1995 Regulations is one way in which a health board can reduce the risk of being sued on foot of foster care placements.
That said, however, it must be impressed upon health board personnel that statutory regulations ought to be regarded as the minimum standards to be observed in cases of foster placements. The mere fact of compliance with statutory requirements will not always be a successful defence to an action in negligence. The facts of an individual case may demonstrate that a health board ought reasonably to have exceeded the minimum standards laid down if, in all the circumstances, its statutory duty to care for the child was to be properly discharged. Health board personnel should be encouraged, through positive staff development and effective training programmes, to regard each case as

[52]Such duties include, *inter alia*, the duty to permit authorised persons to see the child, the duty to co-operate with authorised persons, the duty to notify any change of address and so forth.
[53]Regulation 17.
[54]Regulation 18(1) specifies the minimum intervals between reviews.
[55]Regulation 22.

unique and to ask, as a matter of course, whether the minimum standards provided for in the Regulations need to be exceeded in all the circumstances of the case.

Risk Area 1: Screening Procedures

Many of the cases in Britain and some of the cases that are currently before the courts in Ireland contain allegations of negligence in respect of the non-suitability of foster parents chosen by the relevant authority or health board in question. Clearly, one of the key areas where the risk of litigation may be reduced is in ensuring that the pre-placement screening procedures of prospective foster parents are working effectively.

While the screening procedures specified in Regulation 5(2) should assist health boards in ruling out most unsuitable candidates they are not, in my view, sufficiently specific and health boards are advised to establish clear and objective criteria by which the process of screening is to be conducted.

♦ <u>The Medical Certificate</u>

Clearly, having a medical certificate on file pertaining to an applicant's state of health complies with Regulation 5(2)(a)(i). However, in the event of litigation, a health board should, in my view, be in a position to show that it had procedures in place which demonstrate that, firstly, due cognisance of the contents of the said medical certificate was taken and, secondly, that effective follow-up was instigated, where necessary. A safety check-list in the screening process might, reasonably, include the routine assessment of all medical certificates submitted by applicants. Such routine assessment might include analysis of the following:-

- *Is there anything of note in the medical certificate that gives rise to any issue concerning the suitability of the applicants for foster parenting?*
- *If so, has personal contact (with the applicant's consent) been made with the medical practitioner to clarify or elucidate upon such queries?*
- *If not, why not?*
- *If so, with what result?*
- *What decision has been made in light of the medical report on file?*

Appropriate qualified experts, including medical practitioners, should be engaged to assist health boards prepare an effective and efficient screening process in relation to candidates for foster care.

- Evaluation of References

Health boards must have clear and objective structures in place which ensure the efficient and effective assessment and evaluation of references. Once again, having a reference on file from two persons consulted by the board in relation to suitability is one thing; evaluating such references is another. In the event of litigation arising out of allegedly negligent foster care placements a court, in assessing the question of negligence will consider whether, in all the circumstances, a health board act reasonably in the discharge of its duties. Documentation which establishes that references were given adequate consideration in the screening process will, in all likelihood, assist the board, to some extent, in defending such litigation. Such documentation might include, *inter alia*, evidence of the means of the referee's knowledge of the applicant, the extent of that knowledge, the overall rating of the reference (good, fair, poor) and the response taken, if any, to queries raised by the referee concerning an applicant's suitability to act as foster parent. Once again, suitably qualified professionals with the requisite skills for the proper identification of suitable

candidates should be engaged by health boards so as to ensure that this highly important process is as effective as possible.

It seems to me that good practice would require health boards always to make personal contact (on consent) with referees nominated by applicants for foster care. If there are any queries raised or doubts expressed by referees then, in my view, a health board should not accept such applicants unless and until all queries are answered and all doubts clarified to the satisfaction of the examination committee. Written evidence of such satisfaction together with the basis thereof should be recorded. Where doubts as to an applicant's suitability remain, a health board should not, in my view, proceed to place a child in the care of such a person.

♦ Garda Clearance and Other Information

Once again, structures should be in place which specify the steps to be taken in the procurement of the statement from the Gardaí, the range of the inquiry (what, for example, constitutes a "relevant member of the household"?) and the manner in which such statements are to be evaluated by reference to objective criteria. Health boards should be clear as to the precise information they require at this stage of the screening process. Careful consideration should be given to the kinds of offences/convictions that are to be regarded as threshold offences, the conviction for which would eliminate an applicant from further consideration. A conviction for an offence involving any form of abusive behaviour towards others should, of course, result in the immediate elimination of such a candidate from further consideration. However, care should also be taken not to overlook convictions for offences, such as, fraud or forgery, which raise questions with regard to an applicant's honesty and trustworthiness.

Professionals who are familiar with the needs of children in care are best trained to advise on the type of additional information that a health board might seek in the early screening process. It strikes me that due consideration should be given to the reason why a candidate has applied to become a foster parent. Whilst many applicants might view fostering as a means of providing additional income, it would, in my view, be important to ensure, as far as possible, that this is not the sole or even the dominant reason for an applicant seeking approval as a foster parent. Consideration of this area should, in my view, form part of the objective criteria laid down by a health board by which the selection committee comes to its decision.

That said, however, one way of ensuring that foster-care placements are more likely to be successful is to ensure that undue financial burdens are not placed upon carers. In the United Kingdom the National Foster Care Association (NFCA) has published a report entitled: *Foster Care in Crisis: A Call to Professionalise the Forgotten Service*.[56] The NFCA argues that the present crisis in the system stems from a shortage of qualified carers, noting the stunning increase in fostering by local authorities in the last ten years. The report calls for increased pay and increased training and notes that some 27,000 foster families play a vital role in child care services. The report found that more than 60 per cent of local authorities pay foster care allowances below a level where carers might recover all their costs. In other words, foster-carers lose money.[57] Health boards seeking to reduce the risk of litigation arising out allegedly negligent foster care placements should consider the importance of motivating foster carers to be effective parents and due remuneration for the task they undertake might be an important feature in this regard.

[56]National Foster Care Association, 1997.
[57]See also Oldfield, *The Adequacy of Foster Care Allowances* (Ashgate, 1997).

♦ The Assessment of Suitability

Apart from the documents and information specified in Regulation 5(2)(a), a health board shall not place persons on its foster parenting panel unless an assessment of the suitability of those persons and their home has been conducted by an authorised person. The Regulations do not specify the criteria by which "suitability" is to be assessed and it is imperative that clear, objective and written criteria are identified for determining what constitutes a suitable candidate for foster parenting. Here, once again, the expertise and assistance of suitably qualified personnel will be required in drawing up and evaluating the relevant and objective criteria.

♦ Record Keeping

The importance of keeping clear, objective and contemporaneous records in relation to the screening of potential foster parents cannot be over-stated. A health board that can show that it deployed best practices and that it took all reasonable steps to ensure that an applicant for foster parenting was suitable for that role may reduce, considerably, the risk of being found liable in negligence for placing a child in the care of persons who, subsequently, failed to care adequately for that child.

Unless a health board recorded evidence of the objective and relevant criteria used by it in making its assessment, it will be difficult to resist an allegation of negligent placement if a child is subsequently injured or abused having been placed in foster care. Clear criteria as to what precisely is being sought and how, if at all, the applicants fulfil that criteria must be established.

As stated above, health boards should engage the services of appropriately trained professionals (such as, psychiatrists, general practitioners, parents, teachers, and lawyers) in the establishment of the objective criteria by which an applicant's suitability is to be assessed. Thereafter, the criteria should be applied consistently in all cases. It should be evaluated periodically and the outcome of such evaluation recorded together with specific decisions taken in the light thereof.

The Regulations require that the aforesaid assessment of suitability be conveyed, in writing, to the examination committee. Thereafter, the committee must be satisfied, having regard to the report and the other information specified above, that the applicants are suitable persons to act as foster parents on behalf of the heath board. Once again, the objective criteria by which the committee's satisfaction is to be determined should be recorded in writing.

♦ Training of Foster Parents

Health boards are obliged to ensure that effective advice, guidance and training in the care of children has been given to the foster parents prior to their inclusion on the foster care panel. Details of such training should be recorded. The said advice, guidance and training should be adequate to the task in hand. The opinion of appropriate experts should be obtained in ascertaining the level of training, advice and guidance that would, reasonably, be required in this instance. The identification of and adherence to objective and relevant criteria by which persons are, initially, chosen and, subsequently, affirmed as foster parents will assist the health boards, generally, in the discharge of their statutory duties. Child protection practices in foster care should, of course, be evaluated regularly and, if necessary, amended in the light of new insights.

Risk Area 2: The Monitoring of Placements

♦ The Maintenance of Registers and Records

Whilst the deployment of effective screening procedures is, clearly, one way of reducing the health board's exposure to liability in negligence, the effective monitoring and supervision of children, post placement, is equally important in ensuring that health boards are discharging their statutory duties pursuant to the Act of 1991. Part IV of the 1995 Regulations deals with the monitoring of placements and obliges health boards to maintain a **register** in relation to children placed in foster care. It also obliges a health board to keep **case records** of children in foster care. Whereas the register records salient objective facts about the child, such as, his name, original home address, foster home address, and so forth, the case records consists of a number of documents pertaining to each child's case. Such documents include:

(a) medical and social reports on the child, including background information on the child's family,
(b) a copy of any court order relating to the child or of parental consent to the child's admission to the care of the board, as appropriate,
(c) the birth certificate of the child,
(d) a copy of the contract between the board and the foster parents,
(e) a copy of the plan for the care and upbringing of the child prepared by the board under article 11 of these Regulations,
(f) reports on the child's progress at school, where applicable,
(g) a note of every visit to the child and the foster parents in accordance with article 17 of these Regulations,
(h) a note of every review of the child's case pursuant to article 18, 19 or 20 of these Regulations, together with particulars of any action taken as a result of such review, and
(i) a note of every significant event affecting the child.

If a health board's monitoring of placements is consistent and efficient then the likelihood of an unsuccessful or harmful placement escaping the notice of the board is reduced. Where a board can show that regular and close monitoring of placements formed part of its standard practice and that swift action was taken to remove a child from potentially harmful foster parents, then, in my opinion, it is likely that the risk of a finding of negligence against the board, in this regard, will be reduced. Here again, clear and objective criteria by which the success of the monitoring process can be assessed must be established. An important part of the monitoring of placements will be the maintenance and recording of regular contact with children in foster care. Close monitoring should enable health board personnel to detect problems as soon as they arise.

♦ Regular Visitations and Private Consultations

Procedures to be followed in the event of a problem arising with a particular placement should be drafted and should ensure that clear strategies are in place to protect the welfare of the child at all times. Regular evaluative checks should be carried out to ensure that health board personnel are aware of and are complying with those procedures.

Although the Regulations provide for periodic visiting and supervision of children placed in foster care prudent practice would, in my view, oblige health boards to ensure that, where possible and appropriate, a child placed in foster care is consulted about that care, in the absence of the foster parents. Such private consultations with the child should, in my view, form part of the standard routine practice of health board personnel. Children placed in foster care, particularly long-term foster care, may be desperate to ensure that things

work out satisfactorily and may be slow to divulge information in relation to the non-suitability of their foster parents. Health board personnel should take appropriate steps to elicit the views of the child in relation to the success or otherwise of the placement.

It strikes me that most of the cases involving litigation arising out of allegedly negligent foster care placements could have been avoided had health board personnel employed procedures for the early detection of difficulties. The Regulations provide that, as a minimum, a child placed in foster care shall be visited by an authorised person, as often as the board considers necessary, but in any event:

> *(a) at intervals not exceeding three months during the period of two years commencing on the date on which the child was placed with the foster parents, the first visit being within one month of that date, and*
>
> *(b) thereafter at intervals not exceeding six months.*[58]

The individual circumstances of a particular case may, of course, require a health board to visit a child placed in foster care more frequently than specified in the Regulations. For example, a court could find that, in all the prevailing circumstances of a case, it was unreasonable for a board to leave a child for one month in the care of newly appointed foster parents without satisfying itself that the placement was a safe one.

[58] Regulation 17

Part B: The Duty to Foster Parents

♦ Disclosure of Information

Health boards concerned to reduce the risk of litigation should also be mindful of their duties to foster parents with regard to the extent of disclosure about the child to be placed in foster care. Whilst the Second Schedule of the 1995 Regulations obliges a health board to furnish foster parents with information about the child, the extent of the information listed in the Schedule may not go far enough. The Schedule provides that the following information on the child should be supplied:-

1. *Name, sex and date of birth of child;*
2. *Religion;*
3. *Reason for admission to care of health board;*
4. *Whether voluntary admission or pursuant to court order;*
5. *Particulars of previous placements (if any);*
6. *Names and address(es) of child's parent(s);*
7. *Names, ages and whereabouts of siblings (if any) of child;*
8. *Arrangements for access;*
9. *.Particulars of any medical or nutritional requirements of child;*
10. *Arrangements for child's attendance at school (where applicable).*

However, full disclosure in relation to possible risks associated with fostering a child should be made. In *W v Essex County Council*[59] the Court of Appeal upheld a claim brought by foster parents against the local authority. The foster parents and their four minor children brought actions against Essex County Council and a social worker employed by Essex. The local authority, according

[59] [1998] 2FLR at 278.

to the foster parent, had not disclosed that the child had been abused and had been suspected of abusing others. The claim arose out of the fostering of G, then aged 15 years old, on the ground that the local authority and the social worker were aware that G was an active sexual abuser, it being accepted that G had received a caution three years earlier for indecent assault on his sister. During the month that G spent with the foster family he had sexually abused the children then aged 7 and 12 years. The Court of Appeal held that the local authority in that case owed a duty of care to the foster-parents' family not to place them at risk from a known sexual abuser and that the claims in negligence should not have been struck out.

Part C: Case Law

- *H v Norfolk*: No Duty of Care

In 1997 the Court of Appeal in England confirmed that a child placed with foster-carers by a local authority in a negligent manner cannot sue the local authority for damages which such negligent placement might have caused. In *H v Norfolk County Council*[60] the applicant was a 22 year old man who had been taken into care at the age of 4 and placed with foster parents until he was 14. He alleged that he had been physically and sexually abused by his foster-father and that the council had been negligent in failing to supervise his placement, to investigate reports of abuse and to remove him from foster care. The judge struck out the applicant's claim on the ground that it disclosed no reasonable cause of action. He relied upon the authority of the *Bedfordshire* cases. The plaintiff applied for leave to appeal against the order and contended that the trial judge had failed to distinguish between the instant fostering case and the position vis-à-vis natural parents in the *Bedfordshire* cases. The Court of

[60] [1997] 1 FLR 384.

Appeal, however, held that the same public policy reasons that precluded allowing damage claims against local authorities by children outside the care system must also serve to preclude damages by children *in* foster care. The interlocking roles of the various agencies, the court held, could not be disentangled.

♦ *Barrett v London*:-The Court of Appeal

The Court of Appeal made a similar ruling in another case involving allegations of negligent placement in foster care. In *Barrett (A.P.) v London Borough of Enfield.*[61] the plaintiff was taken into the care of the defendant authority when he was ten months old and remained in care until he was 17. In the Statement of Claim he alleged that the defendant negligently made two placements with foster parents, moved him six times to different residential homes, failed to provide him with proper social workers and failed to make proper arrangements to re-unite him with his mother. He further alleged that such negligent treatment caused him to leave the care of the local authority when he attained the age of majority without family or attachments and suffering from a psychiatric illness leading to his having an alcohol problem and a propensity to harm himself.

Counsel for the plaintiff in *Barrett* argued that where a health authority has been granted a wide degree of discretion in relation to decisions about children, and acts *in loco parentis*, then its duty includes a duty to provide the child with the standard of care which could be expected of a reasonable parent. This duty, it was submitted, included a duty to provide a home and education, to take reasonable steps to protect him from physical, emotional, psychiatric or psychological injury and to promote his development. Moreover, the plaintiff

[61]Brandt J delivered judgment in Court of Appeal. The House of Lords, thereafter, delivered judgment of 17 June 1999.

argued that it was the defendant's duty at all times to provide competent social workers whose responsibility it was to monitor the various aspects of the plaintiff's welfare. The negligence alleged against the defendant consisted of the way in which the plaintiff was placed the various foster parents and homes.

The Court of Appeal *per* Lord Woolf M.R. stated that whilst the policy considerations in fostering cases are not identical to those in the *Bedfordshire* cases (where child was not actually *in* care), nevertheless they were strictly comparable and, taken cumulatively, had sufficient potency to override the competing consideration that "wrongs should be remedied". He added that in relation to decisions of the local authority of which complaint was made

> *. . . it would be contrary to the public interest and therefore not just or reasonable to impose a duty of care.*

As in the *Norfolk* case, the Court of Appeal, relying on *Bedfordshire*, upheld a decision to strike out his claim for failure to disclose a cause of action. Lord Woolf M.R. stated that the very fact that the defendant was stated to have been in the position of a parent to the plaintiff at the material time brings home the public policy aspects of the situation. He held that although a parent could be liable to a child for negligently driving a car he should not, nor should the local authority, be liable in making decisions "with regard to their children's future". The decision was appealed to the House of Lords.

♦ Impact of *Osman v United Kingdom*

It would appear that the stringently applied "policy considerations" that formed the basis of the judgment of the House of Lords in the *Bedfordshire* cases are now under review. The House of Lords in *Barrett* delivered its judgment in

June 1999 and the case indicates, in my view, something of a shift in thinking in that jurisdiction in this area of public law. The reasons for the shift are varied.

It is interesting to note that whilst the House of Lords, in Britain, has, heretofore, refused to impose a duty of care on local authorities in the exercise of their statutory discretion, some of their Lordships have now expressed the view that once the discretion has been exercised and the decision to take a child into care has been made, different legal considerations apply.[62]

Clearly, there is no *logical* reason why a "blanket immunity" from suit that applies to local authorities in respect of statutory discretion exercised prior to taking a child into care should not also apply in respect of those exercised post-admission into care. However, in *Barrett* the House of Lords has overturned the decision of the Court of Appeal which struck out the plaintiff's claim against a local authority for, *inter alia,* negligent placement in foster care.

Thus, it would appear that the "blanket immunity" provided to local authorities in the *Bedfordshire* cases is now under review following a number of decisions from the European Court of Human Rights. The plaintiffs' claims in *Bedfordshire* were struck out for failure to show a cause of action and the House of Lords upheld the decisions of the lower courts in that regard. In a similar claim against a public authority in *Osman v Ferguson,*[63] the Osmans had sought to bring proceedings in the United Kingdom against the police alleging negligence in the prevention of crime. On the basis of the same type of policy considerations that applied in *Bedfordshire,* the proceedings in *Osman* were struck out by the Court of Appeal.

[62]See, for example, the judgment of Lord Slynn.
[63][1993] 4 AER 344.

However, the European Court of Human Rights upheld a claim by the Osmans that their rights under Article 6 (the right to a fair and public hearing) of the European Convention on Human Rights had been infringed.[64]

♦ *Barrett* Reversed

The decision of the Strasbourg Court in *Osman* has clearly influenced the House of Lords as it would now appear to be no longer willing to apply a blanket immunity to local authorities in *Bedfordshire* type cases. In allowing the appeal *Barrett* Lord Browne Wilkinson stated:

> *In view of the decision in the Osman case it is now difficult to foretell what would be the result in the present case if we were to uphold the striking out order. It seems to me that it is at least probable that the matter would then be taken to Strasbourg. That court, applying its decision in the Osman case . . . , would say that we had deprived the plaintiff of his right to have the balance struck between the hardship suffered by him and the damage to be done to the public interest in the present case if an order were to be made against the defendant council.*[65]

Lord Slynn, however, upheld the appeal for different reasons and saw a clear distinction between the *Bedfordshire* cases where children were not, in fact, taken into care and the foster-care cases, such as, the instant one which involved treatment whilst *in* care. He stated:

> *Thus accepting that a decision to take a child into care pursuant to a statutory power is not justiciable, it does not in my view follow that, having taken a child into care, an authority cannot be liable for what it or its employees do in relation to the child.*[66]

[64] *Osman v. United Kingdom (The Times* 5 November 1998).
[65] Ibid. at page 2.
[66] Barrett (A.P) v London Borough of Enfield, (HL) 17 June 1999 at page 5.

Lord Slynn went on to say that the appropriate test at this level is the ordinary test of negligence as provided for in *Caparo*.[67] The court, he said, must have jurisdiction to consider whether there is a duty of care owed and whether it has been broken. He concluded:- *"I do not see how the interests of the child can be sufficiently protected otherwise*."

Whilst the courts in this jurisdiction have not ruled on the specific question of liability for negligent placement of children in foster care, I am of the view that they would be likely to follow the reasoning of Lord Slynn in *Barrett* than that of the Court of Appeal in *Norfolk*. If a court were to find that a child had been injured as a result of a negligent placement by a health board it would, in my opinion, have little difficulty in allowing such plaintiff to recover damages against such a board for negligence and breach of duty.

[67] *Caparo Industries Plc. v Dickman* [1990] 2 AC 605. In this case the Court held that the appropriate test to apply in determining whether liability in negligence should be imposed was threefold: that the injury was reasonably foreseeable, that there was proximity of relationship between the parties and that, in all the circumstances, it would be just and reasonable to do so.

CHAPTER THREE

LITIGATION
AND
THE HEALTH BOARD EMPLOYEE

Part A: Alleged Abuse by Employees

The third category of the child abuse cases currently before the Irish courts involve claims made against health boards for alleged wrongs committed by their servants, agents or employees against children in their care. Creche workers (either employed directly by health boards or under their general supervision), youth workers, care workers and a whole range of people whose work involves contact with children [hereinafter referred to, collectively, as "child care workers"] constitute a source of risk exposure for health boards. Analysis of risk of litigation in this context involves consideration on two fronts:

(1) the risk of litigation from the allegedly abused child and/or its parents; and
(2) the risk of litigation from the allegedly abusive employee.

Risk Area 1: The Child as Potential Litigant

♦ Screening Procedures for Employees

Reducing the risk of litigation in this regard requires that protective procedures are in place for the effective screening and continuous monitoring of persons charged with the care of children. In order to reduce liability in negligence on this front health boards must be in a position to show that all reasonable steps were taken to ensure that persons employed in child care work were properly assessed, suitably qualified and adequately screened for the task in hand. Health boards should ensure that prospective employees are fully cognisant of all the conditions to which their employment is subject. Applicants for employment as child care workers should, in my view, be informed, in writing,

that their engagement will be conditional upon, *inter alia*, a satisfactory outcome of appropriate inquiries being made to the Gardaí, the confirmation of references, the assessment of suitability and the verification of academic/child care qualifications. Once satisfied that a candidate is a suitable person to be charged with the care of children, health boards should, in my view, require the offeree to enter into a written contract of employment agreeing, *inter alia*, to act always in accordance with the health board's code of conduct and professional ethics and to strive to promote the safety and welfare of young people within their care.

Suitably qualified experts should be engaged to assist health boards prepare effective and efficient screening procedures in relation to candidates for child care work. As a minimum, the provisions laid down in the 1995 Regulations relating to the screening of candidates for foster care should be applied, with appropriate modifications, in this regard. Thus, general advices given herein in relation to the evaluation and follow-up of investigations following receipt of medical certificates, character references and Garda clearance certificates are all equally applicable in this context.[68]

Health boards involved in the recruitment and employment of child care workers should ensure that employees are cognisant of and adhere to the 1999 Guidelines *Children First*. Chapter 14 thereof recommends that training in child protection needs to be available at both basic and advanced levels, should be appropriate to the person's professional role and be delivered on a multi-disciplinary basis.

[68] See Chapter Two, pages 44,45 & 46.

Apart from ensuring that effective procedures are in place which prevent persons with a propensity to harm or abuse children from entering the child care system, health boards should also ensure that effective structures which facilitate the ongoing supervision and evaluation of employees are in place. Regular supervision, surprise periodic inspections and consistent evaluation of employees' performances should, in my view, form part of any health board's standard operating procedures. In the context of risk reduction, vigilance is essential.

A child who suffers damage in consequence of abuse by a health board employee, servant or agent, would, in my opinion, have little difficulty in successfully prosecuting a claim against the health board where it could be shown that that the board's screening and/or supervisory procedures were unreasonable, in all the circumstances. The legal basis upon which claims may succeed may differ from case to case. In some instances, the health board, as employer may be found directly liable for negligent hiring and/or supervision of its employees. In other cases, liability might be imposed vicariously upon a health board for damage caused by its employees, servants or agents. Additionally, a plaintiff may succeed against a health board on the grounds of a failure to discharge its duty to the child pursuant to the Child Care Act, 1991 or indeed, for failure to vindicate the plaintiff's constitutional rights.

♦ Liability in Negligence

Traditionally, the common law, while holding a master vicariously liable for the wrongs of his servant, did not impose liability for *all* wrongs committed but only for those which arose out of or were within the scope of his employment. In *The Health Board v C (B) and the Labour Court*[69] Costello J considered

[69][1994] ELR 27.

whether employees were acting in the scope of their employment when they sexually harassed another employee. He accepted that an employer may be vicariously liable when his/her employee acts negligently, or even, criminally. However, he went on to say that he could not envisage any employment in which the employees were engaged in respect of which a sexual assault could be regarded as so connected with it, as to amount to an act within the scope of employment. On the facts of the case before him, Costello J excluded vicarious liability in respect of indecent assaults.

Were a court in this jurisdiction to be satisfied that a plaintiff was abused by a health board employee, it could, in my view, find the health board liable not vicariously, but directly, in negligence and breach of duty. In a number of "abuse" decisions in the United States involving priests allegedly employed by various diocese, the American courts have surmounted the "scope of employment" test by holding that a priest's diocese could be liable, directly, for the injuries caused to plaintiffs.

♦ <u>The United States' Authorities</u>

In *Destefano -v- Grabrian*[70] it was held that a diocese of the Roman Catholic Church could be held liable for negligent supervision of a priest alleged to have entered into an adulterous relationship with a parishioner.[71] The case arose out of marriage counselling between a priest and a married couple in the diocese. The plaintiffs had been experiencing marital problems and sought marriage counselling from the defendant priest. During the course of the counselling, the priest developed a sexual relationship with the wife, which ultimately led to the

[70][1988] Colorado 763 P2d 275

[71]While the court accepted the view that a diocese could be held liable for negligent supervision it found, on the facts of this case, that there was no basis for holding the diocese liable under the theory of *respondeat superior*. The court cited the rule that an employer may be held responsible for tortious conduct by an employee only if the tort is committed within the course and scope of employment.

dissolution of the plaintiffs' marriage. The couple brought an action against the priest for clergy malpractice and against the diocese for negligent failure to supervise the priest, alleging that the priest had engaged in other sexual relationships with women in the diocese, and that his past conduct was known or should have been known to the diocese. In determining the issue of diocesan liability the appellate court held that a person who knows or should have known that an employee's conduct would subject third parties to an unreasonable risk of harm may be *directly* liable to third parties for harm proximately caused by the employee's conduct.

In *Does -v- CompCare Inc.*[72] the Court held that a *prima facie* case of negligent supervision was stated against a Roman Catholic diocese for the sexual misconduct of a priest. The action was brought by several adolescent males alleging sexual abuse by a priest at a hospital in the state of Washington. The action named a Louisiana diocese and its bishop, among others, as defendants. The defendant priest had been working as a priest in the diocese for several years and had been maintained by it in a diocesan house. The court held that there was *prima facie* evidence that a tortious act had been committed within the state, based on the alleged actions of the defendant priest. The court rejected the argument submitted on behalf of the diocese that the alleged acts of misconduct by the priest were "beyond the scope of the employment" relationship between the priest and the diocese, as his employer. The diocese had argued that the defendant priest's acts did not arise out of his priestly activities. The court concluded that there was *prima facie* evidence that the diocese had committed a tortious act by its failure to supervise the priest in question.

[72] 1988 52 Washington App 688, 763 P2d 1237.

However, the appellate court of Ohio upheld a dismissal of a claim against a church organisation for the sexual misconduct of a minister, under a theory of negligent hiring in the case of *Byrd -v- Faber*.[73] The court held that great specificity in pleading is required when a claim is brought against an institution for negligent hiring. In particular, the court stated, a plaintiff bringing a negligent hiring claim against an institution must allege some fact indicating that the institution knew or should have known of the employee's criminal or tortious propensities. Applying this rule, the court upheld the trial court's dismissal of the plaintiff's claim, citing that plaintiff had alleged no fact indicating that the pastor involved had a past history of criminal or tortious conduct which was known or should have been known to the defendant institution.

In summary, the case law of the United States indicates a reluctance for holding an employing bishop or diocese *vicariously* liable for the sexual misconduct of clergy. However, in that jurisdiction, the courts have held various diocese *directly* liable for the negligent supervision of its clergy.

Thus, whilst a plaintiff, in this jurisdiction may encounter difficulty in establishing that a health board is vicariously liable for the abusive acts perpetrated upon children by its employees, insofar as such employees cannot be said to be acting within the scope of their employment, such a plaintiff could, nevertheless, succeed on the basis of a claim in negligent hiring and/or negligent supervision of such an employee. If a claim of direct liability is to be made against a health board in respect of abuse by an employee, a plaintiff must prove that the board was negligent in the manner in which it employed and/or supervised the employee in question. For this reason, health boards must be

[73][1991] 57 Ohio St 3d 56.

able to show that their procedures for screening and monitoring child care workers were based upon sound practice and free from inherent defects. In other words, a board must show that it acted reasonably in all the circumstances.

♦ Liability of Health Boards for Pre-School Services

Health boards have duties pursuant to Part VII of the *Child Care Act, 1991* in respect of pre-school services within their respective areas. Section 51 obliges a person carrying on a pre-school service to give notice to the relevant health board in the prescribed manner. Such persons have, pursuant to Section 52 a duty to take all reasonable measures to safeguard the health, safety and welfare of pre-school children attending the service and to comply with regulations made by the Minister. A health board's duty in this regard is set out in Section 53 which provides:-

> *53.—A health board shall cause to be visited from time to time each pre-school service in its area in order to ensure that the person carrying on the service is fulfilling the duties imposed on him under section 52.*

Where the relevant health board has received notification in respect of a pre-school service, then it may (as an authorised person) enter a pre-school premises for the purposes of inspecting and examining the condition of the school.

Health boards may, from time to time, receive inquiries from members of the public in relation to registered pre-school services. In the context of reducing the risk of litigation, health boards should exercise care in the manner in which they discharge their duties and communicate information about such pre-school services. In *T (a minor) v Surrey County Council*[74] the mother of a baby (T) who was less than one year old, contacted her local authority to inquire about

[74][1994] 4 AER 577.

child-minders. The department was unable to provide the name of anyone suitable or available at that time. When the mother subsequently saw an advertisement by Mrs W for child-minding she contacted the local authority's nursery and child-minding adviser, B, who confirmed that Mrs W was registered as a child-minder. She was told her that there was no reason why T could not safely be left in Mrs W's care. In fact, less than three months earlier, another child in the care of Mrs W had been seriously injured, probably through violent shaking. Two case conferences convened by the local authority, at which B was present, were unable to resolve whether Mrs W had caused the injury. As a result, the local authority took no action to de-register Mrs W, although B advised her, informally, that she should consider minding children between the ages of two and five in future. Soon after T's mother placed him with Mrs W he suffered a non-accidental injury involving serious brain damage similar to the injury suffered by the previous child. T, suing by his mother, brought an action against the local authority claiming damages for personal injuries. T's claim against the local authority for breach of statutory duty and for breach of a common law duty of care failed on policy grounds.[75] However, his claim for negligent misstatement by the local authority succeeded.

The Court held that it was clearly the intention of Parliament that only those persons who were fit to look after children under five should be registered as child-minders and, therefore, a person could not be so fit where there was an unresolved question about a non-accidental injury suffered by a child who had been in that person's care. Earlier authorities were cited to show that there was no cause of action for breaches of statutory or common law duty by local

[75]It is unlikely that the courts in this jurisdiction would apply the same type of "blanket immunity" on health boards for alleged breaches of statutory duty and common law duty as the British courts appear willing to apply on policy grounds.

authorities. However, the court held that if the local authority or its officers informed a parent that there was no reason why a child should not be placed in a particular child-minder's care, when the local authority knew or ought to have appreciated that there was a significant risk in placing the child in that person's care, then, in those circumstances, it could be liable for negligent misstatement. On the facts, it was clear that there was a significant risk to any infant placed in Mrs W's care. Another child had recently suffered a serious and unexplained injury whilst in her care and T's mother would not have placed him with her had she known the true position. It followed that, although there was no duty of care based on failure to cancel Mrs W's registration as a child-minder, the local authority was liable for negligent misstatement.

Part B: The Accused Employee

Risk Area 2: The Employee as Potential Litigant

♦ Allegations and the Right not to be Unfairly Dismissed

As in all criminal matters, persons accused of child abuse are innocent until proven guilty and they retain all their statutory and constitutional rights until such time as they are convicted of the offence in question. In managing allegations of child abuse made against an employee, health boards ought, as far as possible, to act in such a manner as to limit their legal liability in respect of both the allegedly abused child and the allegedly abusive employee.

Perhaps one way of approaching the problem is to identify what would constitute an *unfair* dismissal of an employee accused of such misconduct. To bring himself/herself within the scope of the relevant legislation, an employee must meet certain criteria. Under the terms of section 2(1)(a) of the *Unfair*

Dismissals Act, 1977, dismissed employees are precluded from bringing a claim if they have less than one year's continuous service with the employer who dismissed them. The *Minimum Notice and Terms of Employment Act, 1973*, as amended, lays down a separate but important service requirement which must also be complied with--that the employee must have been normally expected to work for at least eight hours per week.

Where the aforesaid criteria are satisfied employees who believe themselves to have been unfairly dismissed are entitled to seek redress of their grievances by means of the statutory procedures provided. In all instances health boards ought to act quickly, reasonably and lawfully where allegations of abuse are made against one or some of their employees. The welfare of the children committed to the care of health boards is of paramount importance and any action on the part of a board which jeopardises a child's safety or increases a child's pain ought to be avoided. *Children First* contains detailed guidelines for dealing with reported suspicions of child abuse and ought to be followed consistently. Section 12.4.1 of the 1999 Guidelines provides that health boards should have their own internal reporting procedures in place in regard to allegations made against their employees.

In determining how best to deal with allegations of child abuse made against an employee the general principles underlying the *Unfair Dismissals Act, 1977*, as amended, must be followed. Section 6(1) of that Act provides:

> "*Subject to the provisions of this section, the dismissal of an employee shall be deemed, for the purposes of this Act, to be an unfair dismissal unless, having regard to all the circumstances, there were substantial grounds justifying the dismissal*."

Subject to certain exceptions, in cases of unfair dismissal the onus of proving that the dismissal was fair rests upon the employer. Child abuse, if proven, undoubtedly constitutes "substantial grounds justifying a dismissal". Until such proof is to hand, however, health boards should ensure that, in responding to such allegations, a reasonable balance is maintained between discharging its duty towards children in its care, on the one hand, and respecting the accused employee's statutory and constitutional rights, on the other.

Section 6(4) of the 1977 Act provides:

> *Without prejudice to the generality of subsection (1) of this section, the dismissal of an employee shall be deemed, for the purposes of this Act, not to be an unfair dismissal, if it results wholly or mainly from one or more of the following:*
>
> *(a) the capability, competence or qualifications of the employee for performing work of the kind which he was employed;*
>
> *(b) the conduct of the employee;*
>
> *(c) the redundancy of the employee; and*
>
> *(d) the employee being unable to work or continue to work in the position which he held without contravention (by him or by his employer) of a duty or restriction imposed by or under any status or instrument made under statute.*

The significance of this paragraph lies in the fact that it provides that dismissals for "conduct" are deemed not to be unfair. No definition of "conduct" is provided in the Act. It is worth noting, however, that in choosing to refer to "conduct" as opposed to "misconduct", the legislation adopts a neutral position on questions of justification and fairness.

Furthermore, and perhaps more importantly from a health board's point of view, the choice of words underlines a distinction between this Act and the *Minimum Notice and Terms of Employment Act, 1973*, Section 8 of which allows an employer to dismiss an employee without notice because of "misconduct". No definition of "misconduct" is provided in the 1973 Act. In interpreting it, however, the Employment Appeals Tribunal has taken a restrictive view of the types of misconduct which justify dismissal without notice or payment in lieu of notice. I have little doubt, however, that the abuse of child, once proven, would fall within the meaning of "misconduct" as envisaged by Section 8 of the 1973 Act. In *Lennon -v- Bredin* [M160/1978] the Tribunal stated:

> *Section 8 of the Minimum Notice and Terms of Employment Act, 1973 saves an employer from liability for minimum notice where the dismissal is for misconduct. We have always held that this exemption applies only to cases of very bad behaviour of such a kind that no reasonable employer could be expected to tolerate the continuance of the relationship for a minute longer; we believe the legislature had in mind such things as violent assault or larceny or behaviour in the same sort of serious category.*

In the light of the foregoing one can reasonably conclude that a health board would be justified in the immediate dismissal of an employee, without notice, who was "caught in the act" of abusing a child. Rarely, however, will incidents be as clear cut as this and it is more likely than not that a board will be concerned with allegations and suspicions of child abuse. It may, therefore, have to rely on the provisions of the 1977 Act where the range of "conduct" which may justify dismissal is considerably wider than the range of "misconduct" covered by Section 8 of the 1973 Act.

♦ The Requirements of Natural Justice

The recent decision of Barr J in *M.Q. v Robert Gleeson and the City of Dublin Vocational Educational Committee and Frances Chance and the Eastern Health Board*[76] lays down important minimum standards to be followed in the investigation of allegation of abuse by health boards. It also offers guidance on the related significant matters of recording and disseminating information relating to allegations of abuse together with the question of the suspension of an alleged abuser.

This case involved a judicial review of actions of the Eastern Health Board and the City of Dublin Vocational Educational Committee. The applicant, M.Q. was a participant in a Vocational Educational Committee course which led to a Certificate in Social Studies and a Community Care Award which would qualify him to take up a position in child care work.

Upon learning of his involvement on the course the Eastern Health Board concluded, in view of its experience of him and the numerous allegations which had been made about him, that he was not a suitable person to engage in child care work. The health board had received many complaints and matters had been brought to its attention about the alleged conduct of the applicant towards children, including his own, between 1973-1994.

The board formed the opinion that it had a statutory duty to inform the Vocational Educational Committee of its concerns and to recommend M.Q.'s removal from the course, which it did. Upon receiving such information the Vocational Educational Committee removed him from his placement as a play

[76]High Court, 13 February 1997.

assistant in a play centre in Dublin and removed him from the course. The applicant challenged:-

(i) the right of the Eastern Health Board to furnish information about him to the Vocational Educational Committee with a view to having him excluded from the course; and

(ii) the decision of the Vocational Educational Committee to act upon the allegations made about him without giving him an opportunity to defend himself and the decision to exclude him from the course.

This case merits analysis on two grounds. Firstly, it provides guidelines that ought to be followed by health boards in investigating and communicating allegations of child abuse. Secondly, whilst the case did not, in fact, deal with an employee of a health board, it lays down principles that should be followed in deciding whether or not to suspend an accused from his/her position as a child care worker.

The court acknowledged that the 1991 Act confers wide powers on a health board to assist it in the protection and care of children in need. It was satisfied that

> *It is present knowledge or reasonable suspicion of potential harm which is the essence of the health board's obligation to children.*
>
> *In my opinion once a situation comes to the knowledge of a health board relating to children being put at risk, there is no real distinction between present and future risk.*[77]

[77] Ibid. at page 19.

Barr J continued:

> *I have no doubt that in the exercise of their statutory function to promote the welfare of children, health boards are not confined to acting in the interest of specific identified or identifiable children who are already at risk of abuse and require immediate care and protection, but that their duty extends also to children not yet identifiable who may be at risk in the future by reason of a specific potential hazard to them which a board reasonably suspects may come about in the future.*[78]

In referring to the statutory duties of health boards and the requirement of **fair procedures** when dealing with complaints of child abuse Barr J stated:

> *Subject to the proper exercise of its functions in the matter of complaints about child abuse and its duty to afford the applicant the benefit of fair procedures, I have no doubt that in the instant case, on the premise that it had taken appropriate steps to inform itself, the board would have been entitled to form an opinion that the applicant was unfit for child care work and would have had an obligation under Section 3(1) of the 1991 Act to communicate its opinion to the V.E.C. with a view to having him removed from the social studies course on which he was engaged.*[79]

The Court noted that a health board does not have to wait until a child has actually been actually abused.

> *On the contrary, on becoming aware that he proposed to embark on a career in child care and that he was attending an educational course to qualify for such work, the board had an obligation to protect children who in its considered opinion would be at risk of abuse by the applicant should he carry out his stated intention of embarking on a career in that area. Such an obligation would require the communication by the board of its opinion to the V.E.C. coupled with a request to remove him from the course in question.*[80]

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[78] Ibid.
[79] Ibid. pages 19-20.
[80] Ibid. at 20.

The Court noted the difficult circumstances within which health boards are obliged to operate and, in particular, noted the evidential difficulties with which boards are often faced.

> *There are many circumstances which may indicate that a particular person is likely to be (or to have been) a child abuser, but there is insufficient evidence to establish such abuse in accordance with the standards of proof required in a criminal or civil trial. For example, the abused child through fear, family pressure, age or mental capacity may be unable to testify against the abuser or, in the case of repeated physical injuries sustained by a child, there may not be sufficient evidence to rule out accidents and to establish proof of abuse in law by a particular suspect. However, there may be evidence sufficient to create, after reasonable investigation, a significant doubt in the minds of competent experienced health board or related professional personnel that there has been abuse by a particular person. If such a doubt has been established then it follows that a health board cannot stand idly by but has an obligation to take appropriate action in circumstances where a person who the board reasonably suspects has indulged in child abuse is in a situation, or is planning to take up a position, which may expose any other child to abuse by him/her.*[81]

Barr J sets the requirement for a health board to conclude that there has been abuse as comprising of two elements:

- evidence sufficient to give rise to a reasonable suspicion to a competent experienced professional that a particular person has abused; and
- evidence, that such a person is in a situation which may expose another child/children to abuse by him or her.

The court noted that the appropriately qualified person must draw conclusions that are based on evidence.

[81] Ibid., pages 20-21.

♦ The Investigation of Allegations

Barr J stated that the first requirement on a health board is to carry out a reasonable investigation of the allegations referred to it. The requirements of such an investigations were stated by the Courts as follows:-

> *In the ordinary course in serious cases the complaint should be put to the alleged abuser in course of the investigation and he/she should be given an opportunity of responding to it. However, an exception in that regard may arise where the board official concerned has a reasonable concern that to do so might put the child in question in further jeopardy as, for example, where the abused child is the complainant. An obligation to offer an alleged abuser an opportunity to answer complaints made against him/her would arise in circumstances where the board contemplates making active use of the particular information against the interest of the alleged wrongdoer - such as publication to a third party as in the present case or embarking on proceedings to have a child or children taken into care.*[82]

Such an investigation would, as a minimum, require the health board to do the following:-

- Take all reasonable steps to interview the alleged abuser;
- Furnish him/her before the interview with notice of the allegations in short form;
- Give him/her reasonable opportunity to make their defence;
- Carry out such further investigations as might appear appropriate in the light of the information furnished by him/her in response to the allegations;
- Form no opinion as to the complaint until those investigations had been made and the information derived as a result had been carefully assessed.

[82]Ibid. at 22.

♦ Derogating From Standard Procedures

The only situation in which derogation from the above investigation procedures could be warranted is where there is a reasonable concern that to put the allegation to the alleged abuser *might put the child in question in further jeopardy, as, for example, where the abused child is the complainant.*[83]

♦ The Disclosure of Information to Third Parties

In *M.Q. v Gleeson* the Court, having referred to the two cardinal rules of natural justice,[84] emphasised a health board's duty of fairness also by reference to the need to consider:

- The gravity of the allegations made
- The serious consequences for the accused
- The harm done by publication
- The need to check information accurately before referring on elsewhere.

The court stated:

> *A health board ought always to remember that such complaints, if unfounded, have of their nature a potential for great injustice and harm, not only to the person complained of but perhaps also to the particular child or children sought to be protected and others in the family in question. A false complaint of child abuse, if incorrectly interpreted by a health board, could involve the destruction of a family as a unit by wrongfully having the children it comprises taken into care. It may also destroy or seriously damage a good relationship between husband and wife or long-standing partners.*[85]

[83] Ibid.
[84] The court relied on *McDonald v Bord na gCon* [1965] IR 2 17; *The State (Gleeson) v Minister for Defence* [1976] IR 280; and *Beirne v Commissioner of An Garda Síochána* [1993] ILRM 1.
[85] *M.Q. v Gleeson* at pages 22-23.

Where a health board has carried out all of the steps described above and has formed the opinion that the allegations are well founded, it has then an obligation to take appropriate action, including making a report to the Gardaí and/or others. The case makes it clear that the health board must come to a conclusion/decision on the allegation before it can refer it on the Gardaí or another body. The 1999 *Guidelines* incorporates the decision of the court in this case. Section 9.4.1 provides that "*Where a health board suspects that a child has been physically or sexually abused or wilfully neglected, an Garda Síochána must be formally notified*". However, a board is not obliged to await confirmation of abuse before notifying An Garda Síochána.[86]

♦ The Decision to Suspend

The court's observations on the duty owed by the Vocational Educational Committee to the applicant provide helpful guidance as to the circumstances when an employer/course manager is entitled to suspend a person accused of abuse. The principles of natural and constitutional justice must apply. The Court noted that M.Q. was a student in good standing and that the Vocational Educational Committee was required to afford him the benefit of fair procedures in their assessment of the complaints made against him by the Eastern Health Board. Its investigation (and, thus, any investigation conducted by a health board acting as an employer) ought to have included:-

- Obtaining details of the allegations against him;
- Informing the applicant of those allegations;
- Affording him an opportunity to respond;
- Making a determination in the light of the information and the applicant's responses to it.

[86] Section 9.4.1.

The court held that the Vocational Educational Committee (as employer/course manager) could rely on the Eastern Health Board opinion if satisfied that it was reasonably based, unless the applicant's defence established that there was no reasonable justification for it or at least that there were serious ground for doubting its validity.

The court stated that suspension should only be resorted to in exceptional circumstances--such as, for example, when it is established that there are good grounds for believing that children are at risk. Given that no such grounds were established in the instant case, the Court held that the Vocational Educational Committee was not entitled to exclude the applicant from the entire course until he had been informed of and had been given a reasonable opportunity to respond to the allegations made against him.

The High Court set out in detail what it regarded as the mistakes made by the health board and concluded that the board's conduct amounted to a denial of M.Q.'s right to constitutional justice and fair procedures. It held:-

> *In the light of the foregoing, the conclusion is inescapable that the E.H.B. failed in its duty of affording the applicant the benefit of constitutional justice and fair procedures in not furnishing him with information as to the charges against him; in not giving him an adequate opportunity to defend himself; in not taking reasonable care in checking the accuracy of information furnished to the V.E.C. and in taking a crucial decision adverse to the applicant regarding his suitability for child care work without first taking the foregoing steps and reviewing the matter in the light of whatever defence he might raise.*[87]

[87] *M.Q. v Gleeson* at page 33.

The decision in *M.Q. v Gleeson* is an important one in that it lays down the minimum standards (namely, the requirements of natural and constitutional justice) with which a health board must comply if it is to avoid infringing the rights of an alleged abuser. The court noted that the Eastern Health Board has an obligation to protect children from foreseeable risk of abuse. The applicant's history as a family man since 1974 has in it numerous incidents which in all probability can never be either proved or disproved, but collectively pointed to a reasonable conclusion that he may not be a suitable person for work involving care of children. Barr J noted that having reviewed the matter in the light of its obligations to have regard for the principles of natural and constitutional justice, the Board may regard itself as obliged to retain its opinion. Nevertheless, fair procedures must be adopted in arriving at a determination of allegations concerning child abuse.

♦ <u>Procedures for Dealing with Allegations</u>

In the light of the foregoing health boards are advised that in seeking to reduce the risk of litigation from accused employees the following principles should be guide and inform actions taken in response to allegations of abuse:-

1. Where an allegation has been made against an employee, health boards, as employers, should follow the specific guidelines set down in Chapter 12 of the *Children First* as minimum standards. The first priority of any health board, acting as an employer, is to ensure that no child is exposed to risk and that all protective and proportionate measures are taken to ensure this end. The reporting and assessment procedures in respect of the child should be the same as for any child about whom a report of suspected abuse is made.

2. Action against the accused employee should be guided by the agreed procedures, the rules of natural and constitutional justice and the applicable employment contract. Each health board should ensure compliance with section 12.3.1 of the 1999 Guidelines and should have clear written and fair procedures on the action to be taken if allegations of abuse against employees are received. In seeking to reduce the overall risk of litigation health boards will, of course, be mindful of the fact that staff/volunteers may be subjected to erroneous and malicious allegations. Therefore, any allegation of abuse should be dealt with sensitively and support provided for the staff, including counselling where necessary.[88] However, the primary goal is to protect the child while taking care to treat the accused employee fairly.[89]

3. Section 12.2 of the 1999 Guidelines recommend that, "*in general, the same person should not have responsibility for dealing with both the reporting issues and the employment issues. It is preferable to separate these issues and to manage them independently.*" The importance of this recommendation is all the more obvious in cases where the health board acts as employer and as an agency empowered by law to carry out the assessment and investigation of suspected child abuse.

4. The accused employee should be requested, in writing, to attend at an immediate meeting with his/her employer. He/she should be informed of the purpose of the meeting and of his/her entitlement to be represented thereat.

[88]Health boards also are exposed to the risk of litigation by employees who suffer psychiatric injuries by reason of the stressful working environment in which many of them may operate. Consideration of this point will follow in due course. For an interesting account of how support may be given to staff, see "Supporting Staff During Litigation-Managerial Aspects", in *Clinical Risk* Vol. 2 No. 6, 1996 at 189.
[89]Section 12.2.2 *Children First* at page 109.

5. At the meeting the employee should be informed of all of the allegations and complaints made against him. It is not always necessary to disclose the identity of the person/s who made the allegation.

6. The employee should then be given an adequate opportunity to deny the allegations or to explain the circumstances of the incident. He should be told that he is not obliged to say anything and that no inferences will be drawn from a decision to remain silent. If an admission of liability is made then, of course, a health board would, in my view, be justified in dismissing the employee without notice or payment in lieu thereof. I would suspect that admissions are rarely forthcoming in cases of this nature.

7. The employee should be informed of the health board's duty to inform the Gardaí of the allegations upon having formed the opinion that the allegations are well founded.

8. Where the health board, as employer, is of the view that there are reasonable grounds for believing that a child/children may be at risk, the employee should be suspended forthwith from his/her position as child care worker and should not, under any circumstances, be permitted to engage in work involving children, pending the final outcome of the authorities' investigations.

9. Where possible, the employee should be placed in alternative employment [such as, administrative duties] until the results of the investigation are available.

10. The employee's salary should not be reduced nor should any other conditions of his/her employment be altered, save as at paragraph 8 above.

11. In all dealings with the employee, he/she should be regarded as innocent of the alleged misconduct until the contrary is shown.

12. When the results of the authorities' investigations are known the employing health board should then decide the question of the employee's future, if any, with the board.

♦ The Decision to Dismiss

If a health board is satisfied, following the prescribed investigations that the allegations are unfounded then the employee should be reinstated. If, however, notwithstanding a "negative" outcome of investigations by the authorities, an employing health board is still of the view that there are reasonable grounds for believing that children in its care may be at risk by the retention of the accused on its staff, then such a board may be justified in removing such a person from his/her employment. A health board will be required to show that in arriving at such a decision the inquiry conducted prior to removal was a reasonable one and that the decision to dismiss the employee based upon that inquiry was also reasonable.[90]

♦ Lingering Doubts--A Cause for Concern?

Sometimes, notwithstanding "negative" findings from investigations into allegations, a health board may have lingering doubts about the suitability of an employee against whom allegations have been made. Alternatively, it may have

[90] *Hennessy -v- Read & Write Shop Limited* [UD 192/1978].

general concerns about a person's overall suitability as a child care worker. Such a person might, for example, be observed spending a disproportionate amount of time alone with one child contrary to a health board's principles of good practice. For the purposes of this Opinion I shall refer to this category of employee as "a suspected person". In such circumstances, a balance herein needs to be struck between protecting the individual's presumption of innocence, his/her right to a good name and to earn a livelihood, on the one hand, and the board's discharge of its duty towards the children who may be within its care. Could a health board ever be justified in the dismissal of such a suspected person?

Envisage, for example, a scenario where an allegation against an employee is unsubstantiated and the said employee is returned to his/her employment with children. What would a health board's legal liability be, if having reinstated such a person notwithstanding the "history" of an unproven allegation/s, he/she were found, subsequently, to be abusing a child in his/her care? In my view, it may be difficult to defeat a claim of negligence in this regard. Having regard to all the circumstances of such a case and having followed the procedures outlined below, a health board, as employer, may be justified in deciding to dismiss a suspected person whose general behaviour is a cause for concern. Once again, the question of the reasonableness of the employer's conclusion will be in issue.

Except in cases of serious misconduct it will also be necessary to establish that proper warnings have been given to a suspected person if the decision to dismiss is to be justified. In practice, the employer will be expected to show that the employee was:-

(a) formally warned of his or her shortcomings (e.g. breach of code of conduct);

(b) advised of the standards which were required;

(c) given an adequate opportunity to meet the standards;

(d) warned that he or she would be dismissed if the standards were not met.

In the context of unfair dismissals for misconduct, there is no need for absolute proof or even proof beyond reasonable doubt. The only requirement is that the belief should be based on "reasonable grounds". In considering an employer's response to such a scenario the fact that the tribunal or court would have taken a different view in a particular case should not be relevant. In that regard, the statement of principle contained in *McGee -v- Peamount Hospital* is instructive.[91] The case concerned a dismissal for an alleged assault on a patient in care. Having reviewed the evidence, the tribunal considered the sanctions imposed:

> "*The Tribunal is very conscious that dismissal for a man of the claimant's age may be of the gravest consequence to him. They have asked themselves whether a sanction less far reaching in its consequences for the claimant than the dismissal might not have been more appropriate. But they recall that the task of the Tribunal is not to consider what sanctions the Tribunal might impose, but rather whether the reaction of the respondent and the sanction imposed lay within the range of reasonable responses.*"

Consequently, only decisions made by a health board (to dismiss employees whose conduct is deemed inappropriate or unsuitable for a person working with children), which fall outside the "band of reasonableness" will be found to be unfair. As a principle of good practice and as a measure aimed at reducing the

[91] [UD136/1984].

risk of litigation from aggrieved employees, health boards should ensure that appropriate legal advice has been obtained in the drafting and the application of all procedures for the management of allegations of abuse/misconduct against employees.

Part C: Other Areas of Exposure for Health Boards

♦ Liability for Psychiatric Injury

In considering ways in which the risk of child abuse litigation against health boards may be reduced, consideration should also be given to ensuring that employees are not exposed to working environments that are likely to cause psychiatric/psychological damage. There has been little judicial authority on the extent to which an employer owes to his employees a duty not to cause them psychiatric damage by the character of the work which the employees are required to perform. It is clear law that an employer has a duty to provide his employee with a reasonably safe system of work and to take reasonable steps to protect him from risks which are reasonably foreseeable. Whereas the law on the extent of this duty has developed almost exclusively in cases involving physical injury to the employer as distinct from injury to his mental health, Colman J in *Walker v Northumberland County Council*[92] stated that there is no logical reason why risk of psychiatric damage should be excluded from the scope of an employer's duty of care or from the co-extensive implied term in the contract of employment.

In *Walker v Northumberland County Council* the High Court in England noted that, in general, the nature of much of the work in the social services is

[92] *Walker v Northumberland County Council* [1995] 1 AER 737 at 749.

extremely stressful. Mr Walker was a social worker employed by the defendant council as an area social services officer. The court accepted that such work is likely to cause anxiety to those who have difficult and upsetting cases to deal with and who are called upon to participate in decision-making as to how particular cases or groups of cases should be dealt with. Colman J noted:-

> *Amongst the most difficult and stressful cases are child abuse cases. Particular stress is created by many of those cases because social workers often have to decide whether it is justifiable to take the child in question, and perhaps other children, away from the parents, knowing that a wrong decision may have extremely serious consequences, involving the risk of death in extreme cases and of far-reaching effects on the life of the child and its family in others.*[93]

In that case expert witnesses for both parties acknowledged that social work could be of a stressful nature and two of the experts had experience in treating social workers who had developed psychiatric illnesses in the course of their work.

In *Walker* it was argued that an increase in the pressure of work together with frustrations and discouragement resulting from a lack of action by superiors, foreseeably exposed the plaintiff, as a person or ordinary robustness, to increasing stress and that because excessive stress causes mental illness a "real risk" of psychiatric injury must, at all material times, have been reasonably foreseeable to his employer. In those circumstances, it was submitted, the foreseeable risk of psychiatric injury to Walker was sufficiently great for the defendant council to be under a duty to take steps to alleviate his position. The plaintiff claimed that insofar as the council failed to take such steps, it was in breach of that duty and thereby caused him to suffer a nervous breakdown.

[93]Ibid. at 741.

The council's case was that while it conceded that it owed to Mr Walker a general duty to exercise reasonable care to provide him with a reasonably safe working system and to take reasonable steps to protect him from risks which are reasonably foreseeable, there was, in fact, no breach of that duty. It argued that it was not reasonably foreseeable at any material time that Mr Walker's work would impose upon him such stress as to give rise to a real risk of mental illness. Alternatively, it argued, if such risk was reasonably foreseeable, the council did not, in all the circumstances, and, in particular, the budgetary constraints to which the social services department was subject at the time, act unreasonably in failing to relieve the pressure on Mr Walker.

The Queen's Bench Division in *Walker* rejected the "resources" based argument and found in favour of the plaintiff. It held that where it was reasonably foreseeable to an employer that an employee might suffer a nervous breakdown because of the stress and pressures of his workload, the employer was under a duty of care, as part of the duty to provide a safe system of work, not to cause the employee psychiatric damage by reason of the volume or character of the work which the employee was required to perform. On the facts of the case the Court was satisfied that the local authority ought to have foreseen that if the plaintiff was continually exposed to the same workload there was a risk that he would suffer psychiatric damage which would probably end his career as an area manager. The local authority ought, therefore, to have provided additional assistance to reduce the plaintiff's workload even at the expense of some disruption of other social work and, in choosing to continue to employ the plaintiff without providing effective help, it had acted unreasonably and in breach of its duty of care.

Thus, in seeking to reduce the risk of child abuse litigation health boards in this jurisdiction should have regard to their duties to employees generally but, in particular, to those engaged in the difficult and often traumatic work that child protection involves.

♦ Liability to Secondary Victims and Issues of Confidentiality

Health boards are advised to be mindful of the fact that apart from the risk of being liable to a primary victim of abuse, such as, a child, they may also have an exposure to other persons affected by their decision and actions. A parent who suffers psychological damage as a result of the manner in which a board dealt with an allegation of abuse involving his/her child or one who suffered as a result of an apprehension of danger to his/her child *may*, arguably, have a claim in damages. The evolution of case law in respect of injury suffered by persons not within the zone of physical danger is far from complete. Whether recovery may only be had for "shock" induced by fear for one's own safety[94] rather than by fear for the safety of others[95] remains to be determined by the courts. Some judges have intimated that psychological damage occasioned by reasonable apprehension of injury to (oneself or) others, (at any rate, if those others are closely connected with the claimant), affords a valid ground of claim.[96] Though, strictly speaking, such claims are parasitic they should not be regarded as being derivative for the right to succeed may not depend on the success of the so-called primary victim. This is an open question.

In the context of reducing the risk of litigation against health boards consideration should also be given to issues of confidentiality that arise in the delicate and difficult area of child abuse. Whilst consideration of these specific

[94] *Dulieu v White & Sons* [1901] KB 669.
[95] *Hambrook v Stokes Brothers* [1925] KB 141.
[96] See, for example, the speech of Lord Porter in *Hay (or Bourhill) v Young* [1943] AC 92 at 120.

questions are beyond the scope of this Opinion, I will be happy to provide a supplementary Opinion in that regard, should Querist so require.

Part D: Risk Management

♦ Some General Observations

In view of the considerable volume of litigation arising out of sexual and other forms of child abuse in recent years, limiting risk in child care practices must be considered a priority by health boards if their statutory duties are to be discharged competently and effectively. Health boards must regard it as timely to consider the full scope of risks in child care practices and to examine and implement strategies for risk containment. Health boards, in my view, are exposed to liability not just in the discharge of their statutory duties to children and others but also in the area of a common law duty of care and a duty to have regard for the constitutional rights of persons with whom they interface. As employers they are also exposed to direct and vicarious liability for the acts of their employees, servants or agents. This Opinion has attempted to indicate a number of areas in which risk exposure is obvious and has offered certain principles that should inform the development of child care practices in the future if the risk of litigation is to be reduced.

Complaints of negligence and breach of duty made against health boards and their employees in civil actions must be a source of considerable anxiety. In this jurisdiction there is, in my view, little room for doubting the existence of a duty of care on the part of health boards and liability for alleged breaches thereof is the issue that will, most frequently, fall to be considered. However, the liability, even if proved, must be regarded by the courts as causative for a

case to succeed. Many children whose cases come to the attention of health boards will already have suffered considerable psychological damage and distress[97] and, apart from the question of liability, we have yet to see how the courts in this jurisdiction will rule on the question of causation.

The risk of civil litigation can be reduced where sound child care practices, common sense and strategies for avoiding harm to children and others are deployed. It is not the purpose of this Opinion to describe how to prevent mistakes being made; indeed careful observation, evaluation and rectification of obviously erroneous practice will usually avoid trouble. The intention is to highlight circumstances which have in the past resulted in litigation and to suggest ways in which current practices may be improved so as to reduce litigation in the future.

In my view, it is imperative that health boards develop both personal and practice strategies to reduce the risk of negligence; not only so as to minimise the possibility of litigation, but also to reduce, as far as possible, the risks to which children, their parents and health board employees are exposed. Legally, the actions of a health board will be measured against those expected of "a reasonably competent health board". Whilst the precise standard is difficult to define, it can be expected that such a health board would work within an acceptable administrative framework, have requisite knowledge and skill appropriate to the task of child protection, work efficiently with other agencies involved in children's welfare and embrace acceptable professional attitudes. All of these factors are relevant to risk management in child care.

[97]For an account of characteristics of referred families and the significant problems that attach to them see "Protecting Children Under the Child Care Act 1991---Getting the Balance Right" by Buckley and O'Sullivan in *Irish Journal of Family Law* Vol. 1 February 1999 at page 11.

Health boards need to have an agreed policy on various administrative matters and, ideally, this needs to be set out in the form of a protocol. Some aspects will entail personal responsibility, others will be collective. Positive staff development and proactive expert training designed to motivate every employee towards a sense of personal ownership of the board's objectives in child protection must, in my view, generate an environment more conducive to safe practice and non-negligent behaviours. Record keeping is of fundamental importance. Legible, clear, comprehensive, contemporaneous records are invaluable when responding to a complaint or allegation. They should include the thinking behind the decisions, a feature in itself important to other professionals who may be involved in a child's case. There may be an unstated convention that positive findings and actions be recorded, but negative findings are often relevant. Justification for non-visiting of children in foster care needs recording. Confidentiality is expected, but sometimes broken unwittingly. Good communication is vital to effective child protection. Much litigation, in general, is the result of poor communication and a sense of frustration and insult on the part of plaintiffs. People do not like to be ignored, patronised or not taken seriously. Legal redress may seem to them to be their only course. Writing in the context of medical malpractice litigation David Starke, Risk Manager of University College London Hospitals NHS Trusts, states:-

> *We have demonstrated that patients who are basically well disposed towards the Trust are unlikely to sue when something goes wrong. Conversely, those who have been frustrated and angered by ineptitude in the managing process, unnecessary stonewalling and bureaucracy, may well consider legal action which might otherwise have been furthest from their intentions. Too often patients seem to have resorted to litigation as the only way to obtain a sensible response from the organisation.*[98]

[98]Starke & Boden, "Experiences of a Risk Manager: View from the Battlefront" in *Clinical Risk* Vol. 3 No. 1 January 1997.

Continuing education and in-service training is an important characteristic of a professional public body. In a rapidly developing field it is expected that a professional health worker will keep up to date. Maintaining a constructively critical approach and an awareness of individuals' limitations will also help. Acting responsibly towards children, their parents and health board employees combined with personal vigilance in protecting their interests, reduces the overall risk of litigation arising.

CONCLUSION

In short, the importance of the following cannot be overstated in the context of seeking to reduce the risk of child abuse litigation against health boards:-

- the institution of standardised procedures aimed at effective identification and immediate response to children at risk;

- the consistent application of the four step test of reasonableness in the exercise of discretionary powers;

- the compliance with the Department of Health and Children Guidelines *Children First* as minimum standards of safe practice;

- the deployment of effective procedures for the collation and response to information about children in need of care and protection;

- the maintenance of accurate, confidential and contemporaneous records in relation to the care of children;

- the implementation of effective screening procedures for the assessment of persons considered for work with children (foster parents/child care workers);

- the conduct of ongoing supervision/evaluation/review of persons involved in child care; and

- the application of fair procedures and the principles of natural and constitutional justice in the management of complaints against accused persons.

Health boards facing increased litigation in the area of child abuse might, usefully, consider the appointment of a Risk Manager whose function would include the education of all staff in the importance of risk reduction. Managers and staff need to be made aware that risk management is not simply an ad hoc attempt to prevent adverse incidents or to minimise problems and their consequences when they occur; it is a formal method of harnessing risk. All things considered, it supports staff and improves the reputation of a health board for effectiveness, integrity and openness in the discharge of its statutory duties.

Nothing further occurs.

ANN POWER **July *2000***

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