3.2 THE SOUTH EASTERN HEALTH BOARD[46]

The Ferns Inquiry would like to acknowledge the comprehensive and informative submission prepared by the South Eastern Health Board for the purposes of this Inquiry. This document set out the statutory, legal and administrative framework of the Board and was a valuable resource to the Inquiry.

The South Eastern Health Board is a statutory body created by the Health Act, 1970 and therefore only has such powes as are conferred on it by statute. This Act vested statutory responsibility for administering health services in eight regional Health Boards (the Eastern Regional Health Authority was established by later legislation). Section 6 of that Act conferred on the Health Boards the functions previously carried out by the local authority in relation to the provision of health care in the community. While Health Boards began to take children into care following applications under the 1908 Act in the mid-1970s, it was not until emergency legislation – The Children Act 1989- that this activity was (retrospectively) legally sanctioned by designating The Health Board as "a fit person" for the purposes of such applications[47].

The Children Act 1908 provided the main statutory provisions for protecting children at risk until its amendment by the Child Care Act 1991. The 1991 Act was not fully operational until 1996 and it was therefore the 1908 Act that was the relevant legislation at the time when most of the cases looked at by this Inquiry arose. The limited protection which this Edwardian legislation provided was to identify categories of children who, because they were orphaned, neglected or abused lived in circumstances of extreme misery and to empower courts of summary jurisdiction to remove the child from the neglectful or abusive parent and place him or her in an alternative situation. An application to the court for such an order could be made by 'any person'. The categories of children identified in section 58 were those found begging, wandering, and destitute, under the care, or in the company of reputed criminals or prostitutes; and those in the care of parents or guardians unfit to have such care. The powers of the court under the 1908 Act also extended to cases where the parent or guardian satisfied the court that they were unable to control the child in question and also to cases where the child had failed to comply with the Elementary Education Act 1876.

It is possible to identify clearly the scheme of the 1908 Act from the power which it conferred on the courts. That power was to remove a child from parents who had neglected him or her and to entrust the child to the care of a state agency or a fit person approved by the Court. The powers conferred by the 1908 Act afforded no protection to children who had been abused otherwise than through neglect or abuse

[46] During the course of this Inquiry, the Health Services Executive was established and has taken on the functions of the former health boards. For the purpose of this report, the original title of South Eastern Health Board (SEHB) will be used.
[47] The State (D and D)-v- G and others 1990 IRLM 136. It was held that Health Boards were not "a fit person" within the meaning and for the purposes of the 1908 Act.

by parents or carers. The Child Care Act 1991, had a more pro-active orientation and conferred a general obligation on Health Boards in the following terms:

Section 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 coordinate 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 children as the first and paramount consideration, and

(ii) insofar as is practicable, give due consideration, having regard to its 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."

Health Boards, therefore, have a wide remit to inform themselves in relation to the needs of children in their area and an obligation to promote their welfare as well as responding to concerns about children. However, the actual powers conferred upon the Board to secure the protection of children are not significantly wider than those provided for in the Act of 1908, and would appear to be appropriate primarily in cases where the injury to the child is caused or permitted by the abuse or neglect of a parent or carer.

Just as in the Act of 1908, the Child Care Act 1991, expressly recognised that it was the right and duty of parents to care for their children and that it was the right of children to be cared for by their parents. Intervention by any State agency could only be permitted and required where it was established that parents had failed in this duty to the serious detriment of their child.

The Act of 1991 does not attempt to categorise children in need but in Section 16 describes them in general terms as follows:

"Where it appears to a Health Board with respect to a child who resides or is found in this 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 an application for a Care Order or a Supervision Order, as it thinks fit."

The requirement that the Health Board must satisfy the Court that the child in question is *'unlikely to receive'* the requisite care or protection means that the power of the court only arises where it is satisfied that the parent or guardian of the child is unable or unwilling to provide the appropriate degree of care. It is the right and duty of the Health Board to apply for a Care Order or a Supervision Order where such parental failure can be established. Where a child is abused physically or sexually without the connivance of his or her parents or any inability or unwillingness on their part to provide proper care and protection (which may be referred to as the extra-familial case) the 1991 Act confers no express statutory power on the Health Board to intervene directly.

Section 18 of the Act of 1991 provided for a Care Order and Supervision Order respectively. A Care Order commits the child to the care of the Health Board for as long as he remains a child or for such shorter period as the Court may determine.

A Supervision Order authorises the Health Board to visit a child on periodic occasions where it believes that the child could be at risk. The Act envisaged the establishment of Child Care Advisory Committees in each Health Board district to advise the Health Board on the performance of its functions under the Act.

The Domestic Violence Act 1996, empowered the Health Board acting on behalf of an applicant, to seek a safety order or a barring order by way of application to court to protect a spouse or cohabitee, or child or dependant of such spouse or cohabitee, from violence or the threat of violence.

The Children Act 1908, has been replaced by the Children Act 2001, which is primarily concerned with the law relating to juvenile offenders. As with the 1908 Act and the Act of 1991, this Act does not deal with the issue of protecting children from danger in the community. It reiterates the principle that the State should only intervene in the welfare of a child where the family fails to ensure it.

The High Court considered Section 3 of the Child Care Act 1991 in a case reported in 1997 entitled *MQ v Robert Gleeson and Others.*[48] A student of social studies and community care sought judicial review of a decision by the VEC to suspend him from his course following information passed on to them by the Health Board regarding his inappropriate conduct with children.

A material part of the judgement concerned the scope of the duty owed by the Eastern Health Board to children. Considering this question, Barr J. referred to s. 3(1) of the Act and the wide duty which that section imposed on the Health Board. He went on to say that:

"The Act (and other legislation providing for the welfare of children) is silent on the obligations of Health Boards in taking appropriate measures to protect unidentified children who may be put at risk in the future by a person who, to the knowledge of a

[48] [1997]IEHE 26

Board, intends to enter the realm of childcare work and who the Board has good reason to believe is unsuited for such work and represents a potential hazard for children who come under his / her care."

Barr J. held that the statutory function of the Board was not confined to acting in the interest of specified, identified or identifiable children who were at risk of abuse and required immediate care and protection, but extended also to children not yet identifiable but who might be at risk in the future for the reason of a potential specific hazard to them which a Board may reasonably suspect may come about in the future. In those circumstances Barr J. upheld the decision of the Health Board to inform the VEC of their concerns. He held that the Health Board had an obligation to disseminate the information about the alleged child abuse but expressly held that before doing so, the Health Board was bound to take steps to interview the student and give him a reasonable opportunity to make his defence to the allegations. Furthermore, Barr J. held that the VEC was bound under the principles of natural and constitutional justice to afford their student an opportunity of responding to the allegations made before suspending him from the course of studies.

In addition, Barr J. made further observations in relation to the powers and functions of Health Boards:

"a Health Board has a child protection function which differs fundamentally from the prosecutorial function of the police and the DPP. In the former, the emphasis is on the protection of vulnerable children. In the latter, the objective is the detention and conviction of child abusers. There are many circumstances which may indicate that a particular person is likely to be (or 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. ....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 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, or is in the situation, or intending to take up a position, which may expose any other child to abuse by him / her".

It appears, therefore, that Health Boards have under the Act of 1991, an implied right and duty to communicate, subject to certain legal conditions being fulfilled, information in relation to a possible child abuser, if by failing to do so the safety of some children might be put at risk.

The implication of the imposition of such a duty on the Health Board without any express legislative powers is an issue which the Inquiry believes should be carefully considered by the Legislature. Guidelines, either statutory or regulatory would appear necessary in order to clearly delimit the Health Boards' obligations under Section 3 of the 1991 Act. This is particularly the case in view of the Attorney General's advice given to the Gardai in 1999 that they should inform the appropriate Health Board of all investigations of child sexual abuse irrespective of the source of the allegation giving rise to the investigation, be it anonymous, rumour, suspicion or otherwise.

Indeed, only in cases where the Gardai are satisfied that there is a real danger to children will they themselves notify an employer of an allegation.

In 1998, legislation was enacted to protect people who reported suspicions of child sexual abuse. The Protection for Persons Reporting Child Abuse Act 1998 provided immunity from civil liability to any person reporting child abuse reasonably and in good faith to designated officers of the Health Board or to any member of the Garda Siochana. It provided protection for employees who reported child abuse from all forms of discrimination, including dismissal.

The Act created a new offence of false reporting of child abuse where a person made a report to the appropriate authority "knowing that statement to be false". This was designed to protect innocent persons from malicious reports.

Prior to the enactment of the 1991 Act, a series of guidelines were issued in 1977, 1983 and 1987 by the Department of Health. These guidelines offer a useful history of the development of awareness of child sexual abuse in the community from the mid-1970s to the present day.

These guidelines provided helpful information to those operating in child protection but they had no legislative effect and accordingly could not impose legal obligations or exempt persons from obedience to laws duly enacted. Further guidelines entitled 'Children First' published in 1999 were careful to emphasise this and stated on page 18:

"These national Guidelines are directed at Health Board personnel, An Garda Síochána, other public agencies, voluntary and community organisations and private citizens. In the case of the Health Boards, the national Guidelines are being issued in the context of the Child Care Act 1991. In the case of other agencies and individuals, while the national Guidelines do not have a legislative background, the intention is the development of good practice in this important area of public policy".

The first Expert Group established by the Department of Health to examine the problem of non-accidental injury to children was convened in May 1975. The Memorandum on Non-Accidental Injury to Children (1977) was developed by a committee heavily weighted with medical personnel. An important recommendation of these 1977 guidelines was that case conferences should be seen as an essential part of a team effort to deal with this problem. It was recommended that apart from medical personnel, the case conference should also include social workers, teachers and where appropriate, the Gardai. The Health Board was perceived as having a role in establishing a coordinating authority at local level which would ensure that arrangements for dealing with non-accidental injury to children were satisfactory and were kept under review.

The 1977 guidelines were revised in 1980, and in 1987 Guidelines on Procedures for the Identification, Investigation and Management of Child Abuse were issued by the Department of Health. For the first time, the issue of sexual abuse of children was dealt with. The problem of sexual abuse as identified in 1987 tended to be seen as a problem within families and as requiring a particular response by child care

professionals. Abuse by non-family members or by strangers was essentially a matter for the Gardai and the families of the abused child.

Paragraph 3 of the 1987 Guidelines outlined the duty of any person who knew or suspected that a child was being harmed, or was at risk of harm, to convey his concern to the local health board. It stated that all reports of child abuse (including anonymous calls) should be investigated. In its section dealing with sexual abuse, the Guidelines stated:

"Sexual abuse of children, like other forms of abuse, has always existed. In recent years professional staff have realised that its prevalence is much greater than previously assumed. The number of cases being identified is increasing and this trend is likely to continue as professional staff becomes better able to recognise sexual abuse and as the public become more willing to report cases or to seek help".

It went on to say:

"Any complaint of sexual abuse made by a child must be taken seriously. The complaint should be followed up by the initiation of the necessary investigation and validation process. Professional staff should take particular care to ensure that the initial verbal complaint by the child to them is preserved in writing."

Importantly, the 1987 Guidelines recognised that all suspected cases of child sexual abuse should be reported to the Gardai. They also contained some important observations in confronting the issue of child sexual abuse and in particular, they stated:

"………the important element in extra familial abuse is to support the family and to ensure that parents are secure in their role as primary advocates for their child"

What was clear from the Guidelines was that the Department of Health recognised the role of the Health Board in protecting children where the family failed to do so and saw itself as essentially a support to a family that found itself confronted with child sexual abuse from outside. However, the family would have a right to decline such support and the Health Board would have no power to impose it.

The Inquiry is aware through the direct evidence of Bishop Brendan Comiskey that he knew of the 1987 guidelines and was informed by them in dealing with an allegation of child sexual abuse in 1990. He suggested that the parents of the victim, who had initially come to him with an allegation, should speak to a general practitioner who would then be obliged to report the allegation to the Health Board and through them to An Garda Síochána. This is in fact what occurred. Bishop Comiskey did not believe it was appropriate to use these Department of Health guidelines in dealing with allegations received about priests where those allegations were made by adults. The guidelines do not deal with the issue of whether the reporting recommendation should vary if the victim is an adult at the time of making the report, but in circumstances where the perpetrator is still in a position to abuse children, the rationale for such reporting remains. Reporting complaints by adults has now been adopted by the Framework Document as being an appropriate response to all

allegations of child sexual abuse especially those allegations with continuing child protection implications.

Further guidelines entitled 'Notification of Suspected Cases of Child Abuse between the Health Boards and An Garda Siochana Gardai' were published by the Department of Health in 1995[49], which purported to oblige the Health Board and An Garda Síochána to notify cases of suspected child abuse to each other and to establish a joint method of investigating cases. These guidelines were referred to as 'administratively mandatory' at the time and reflected a concern, identified in the Kilkenny Incest Investigation (1993), about lack of communication and inadequate exchange of information between the two organisations. These guidelines were subsumed into "Children First" (1999).

This Inquiry has looked in detail at the guidelines entitled "Children First, National Guidelines for the Protection and Welfare of Children" which were introduced by the Department of Health and Children in 1999. Like the 1987 guidelines, these guidelines were intended to assist people in identifying and reporting child abuse and in improving professional practice in both statutory and voluntary agencies and organisations that provide services for children and families. They sought to clarify the responsibilities of various professionals and individuals within organisations and to enhance communication and coordination of information between disciplines and organisations. These guidelines set out clearly the responsibility, albeit not a legal one, of any person who suspected that a child was being abused, or was at risk of abuse, to report his concerns to the Health Board. The guidelines point out that a suspicion not supported by any objective signs of abuse would not constitute a reasonable suspicion or reasonable grounds for concern. As with all previous guidelines, the main issue sought to be addressed was neglect or abuse by parents or carers.

Children First has outlined a system for collaboration and co-operation through liaison management teams comprised of a social work team leader and a district based inspector or sergeant from the Gardai. It is fully recognised by the Health Board that no investigation should be carried out by them which would jeopardise any criminal prosecution; their role being mainly one of assessment.

It is clear that the general focus of these guidelines was to assist officials of the Health Boards and other agencies and persons in dealing with the problem of injury (whether psychological or physical) to children caused by the abuse or neglect of their own parents or others in *loco parentis* to them. A constant theme within the guidelines is the need and difficulty in identifying children who had been abused. Reliance had to be placed upon the observations of experienced teachers; suspicions of family doctors and perhaps rumours circulating in the neighbourhood. The concerned persons were encouraged and required to communicate their suspicions or concerns to the Health Board who would collate the evidence or suspicions; meet and confer with the interested parties and, where appropriate, apply to the district court for a Care Order or other such order considered necessary.

[49] See p61 below

The Guidelines have little application to the case where a person (whether an adult or child) made a specific allegation that he or she was sexually abused as a child other than by, or with the connivance of, his or her parents or guardians. In such cases a Health Board may be in a position to offer counselling or support, or notify employers or potential employers in certain circumstances, but the agency primarily responsible for handling the allegation of that serious criminal offence is An Garda Síochána.

Public Inquiries into particular cases of child abuse illustrate very clearly the important distinction between the parental neglect or abuse situation and the case of extra familial abuse. The Kilkenny Incest Investigation (1993), The West of Ireland Farmer Case (1995) and the Kelly Fitzgerald Case (1996) were all concerned with allegations of parental neglect or abuse and raised questions as to the due discharge by the relevant Health Board of its statutory functions. The Madonna House Inquiry (1996) focused on the abuse or neglect of children in residential care by staff and management who were entrusted with their care and protection. The Inquiry into Matters Relating to Child Sexual Abuse in Swimming (1998) investigated the adequacy of arrangements then in place for the protection of children engaged in the sport of swimming. It was not suggested that the Eastern Health Board, in whose area the swimming facilities were situated, had any active role to discharge in relation to the protection of children from the wrongdoing of the coaches employed there.

The Health Board has no express statutory power to obtain or seek a court order prohibiting a person suspected of child abuse from having contact with the child otherwise than in the context of the family home. The Health Board does not currently have statutory powers to prevent a suspected abuser from acting in a capacity such as a teacher or sports coach or indeed a priest which would bring him or her into close contact with, and afford him or her ready access to, young people. Essentially it is a matter for parents and guardians to determine the school their children will attend or the sports facilities they should utilise. It would require very exceptional circumstances for a Health Board to satisfy the court that the decision of competent and caring parents to send their child to a particular school was so irresponsible and unreasonable that the child should be taken from the custody of those parents or guardians and placed in an institution or a foster home.

The duty of the Legislature to protect children in the community from potential harm was recognised and dealt with in The Employment Equality Act 1998 (No. 21 1998). In the judgment of Hamilton C.J. delivering the decision of the Supreme Court in *In Re Article 26 and the Employment Equality Bill* ([1997] 2 IR 321), the Supreme Court upheld the exemption from the requirement of that legislation contained in s.16(4) of the Bill which provided that none of the provisions of the Bill required *"an employer to recruit, promote or retain an individual if the employee had a past criminal conviction for unlawful sexual behaviour or anything that was considered on the basis of reliable information that he engages in or has a propensity to engage in unlawful sexual behaviour."* The Court accepted that this exception was based on the need to protect children from abuse and the general terms in which the exceptions were expressed were appropriate to achieve this purpose.

The Inquiry has been advised that the legislation permitting an employer (or other person in authority) to dismiss an employee from employment on the basis of

comparable information as to the history or propensity of the employee would enjoy the same status of constitutionality.

The Inquiry suggests that consideration should be given to conferring express power on the Health Services Executive to apply to a court of competent jurisdiction for an order prohibiting a named person from engaging in an activity which would give him a ready access to children at all, or otherwise on such terms that the Court might direct. The Court would have to be satisfied by such evidence as the Health Services Executive might adduce that there was a reasonable suspicion that the person concerned represented a potential hazard for such children because of a propensity on his part to sexual abuse.

Administrative Structure of the South Eastern Health Board.

The South Eastern Health Board covers the counties of Kilkenny, Carlow, Wexford, Waterford and South Tipperary. The work of the Health Board is divided into three distinct areas: Community Care, General Hospital Services and Special Hospital Services.

When it was first established in 1970, the South Eastern Health Board was managed by a Chief Executive Officer to whom a Programme Manager for each of the three distinct areas, (hospitals, general and special and community care) reported. The Programme Manager for Community Care had four local managers reporting directly to him who, in turn, liaised with specialist departments covering all aspects of community care. Although the Health Board had responsibility for children in the community and was responsible for setting up vaccination programmes in schools and health examinations, there was no Health Board executive dedicated to child care or child protection. This did not occur until 1998 when the Health Board was restructured to provide for Child Care Managers reporting directly to the General Manager for Community Care. This restructuring also provided for social workers who also report to the General Manager.

Up to 1998, the most senior person in charge of Community Care was the Director of Community Care and Medical Officer of Health (DCC/MOH). This person, a medical doctor, managed the health care services in a community care area and assessed priorities for health care needs in the community. Under the Department of Health Guidelines which were published in 1987, the responsibility in relation to child abuse rested with the DCC/MOH within the community care programme. He/she was the person to whom all cases were notified and who was to ensure that all necessary information was gathered. He/she was also charged with the duty of arranging case conferences and communicating with other agencies.

The social worker was another key person in the structure of the Health Board. Before 1993, social workers were employed to provide a community based range of services to a variety of client groups including the elderly, the disabled, children and families. According to the South Eastern Health Board, the demands of family and child care meant that increasing effort needed to be concentrated on this area, and social workers with skills in dealing with children were recruited from the mid 1980s onwards. Other key personnel in child welfare at that period were public health nurses, public health doctors; child psychiatric staff was not employed until the latter

part of the 1990s. Practitioners not directly employed by the health board, such as General Practitioners, were also expected to cooperate with the child protection network by making reports and attending case conferences.

Each discipline was, according to the Guidelines, heavily dependent on the ready willingness, cooperation and participation of other professionals, within the community care structure, across the community and hospital interface, with general practitioners and with other professionals including Gardai, teachers and voluntary child services. The case conference was and still remains the crucial link between all personnel working in child protection. It occupies a central position in the decision making process in individual cases.

Garda/Health Board Liaison

The Report of the Kilkenny Incest Investigation, which investigated the way in which a particular incident of child sexual abuse was handled by the Health Board and the Garda Authorities, criticised the communication between the different agencies involved. The Health Board and An Garda Síochána have since 1995, established a much closer exchange of information. There are obvious problems and tensions in the respective objectives of each agency – the Health Board must prioritise child protection whilst the Gardai must prioritise a criminal conviction.

In 1998 an Assistant Garda Commissioner sought advice from the Attorney General on whether it was properly the role of the Gardai to inform employers or family members where a rumour or innuendo existed in respect of any individual. The Attorney General's advice was that such information should be passed on to the Health Board in all cases and that that body could pass on any information to third parties such as employers, as it deemed appropriate. The Attorney General's advice stated *"The principal avenue for disclosure of sensitive information to third parties for the protection of children should be through Health Boards rather than the Gardai"*. This advice was clearly given with reference to extra-familial abuse as well as family abuse.

This would appear to be a further example of the general duty inferred from Section 3 of the 1991 Act although as already stated; no legislative or regulatory guidelines have been established for such a duty.

The Inquiry has made some recommendations in respect of Health Board/Garda collaboration at Chapter Eight of this Report.

The Inquiry has been informed that irrespective of whether a complainant requested confidentiality vis-à-vis the Gardai, practice was such that all identifying information concerning cases of alleged child sexual abuse were supplied to the Gardai in the first instance. In situations where there were particular sensitivities for complainants around that, the Health Board and Gardai processed the situation over a period of time whereby the timing of identifying the alleged victim was negotiated. The Inquiry has also been informed by a Health Board that the Gardai would have communicated with them in all situations where they could not proceed with an investigation because a complainant would not make a formal complaint to them.

In relation to the policy adopted where the complainant was an adult and deemed capable of bringing the matter to An Garda Síochána, the Health Board officials spoken to by this Inquiry were not aware of any formal policy having been adopted by the Health Board regarding adult complaints.

The Inquiry has been informed by a former Director of Community Care in the South Eastern Health Board that since 1995 all cases of child sexual abuse that came to the attention of the South Eastern Health Board were reported to An Garda Siochana .

The Inter-Agency Review Committee

The Health Services Executive has been represented on the Inter-Agency Review Committee[50] by the child care manager, Mr Joe Smyth, and a principal social worker. The existence of a Committee composed of high level representatives of the Garda Síochána, the Health Services Executive and of the organisation concerned would facilitate the necessary three-way exchange of information particularly in relation to suspicions, rumours, or unsubstantiated allegations of sexual abuse which are difficult for any one agency or authority to investigate adequately. The collation of such information would be of particular importance to the Health Services Executive and assist it *'to promote the welfare of children in its area who are not receiving adequate care and protection'* as required by Section 3 of the 1991 Act. The Inquiry believes therefore that it should be the responsibility of the Health Services Executive to convene these meetings and to collate and maintain records arising therefrom..

[50] See p42 above